The role of occupational therapy, physiotherapy and speech and language therapy in education support services in South Africa

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KEYWORDS

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ABSTRACT

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This thesis investigated the education support services provided by occupational therapists, physiotherapists and speech and language therapists in the Western Cape Province of South Africa. Changes in the education policy in South Africa to an inclusive education system have major implications for the way therapists provide support. Therapists have been challenged to move from a medical model of support with a focus on highly specialised treatment for a small number of individual learners with disabilities, to a systemic and health promoting model which focuses on support for the education system, including all learners, teachers and parents. The aim of this research was to develop an appropriate and integrated approach for therapists to support schools within an inclusive and health promoting schools framework in South Africa.

Participatory action research using quantitative and qualitative methodology was used. Two surveys were conducted in the Western Cape Province. The first was a survey of all therapists to determine who was working with pre-school and school-aged learners and where. The second survey was of all therapists working in special schools and a small number of private practitioners to identify the roles of the therapists in providing direct and indirect support. In two of the seven education districts in the province, focus group discussions were held with 45 teachers from special and ordinary schools, and 21 parents of school-aged learners – to identify the support they needed. Workshops, incorporating focus groups, were also held with the therapists to, firstly, identify the support they

needed to give to learners, teachers, parents and the education system and, secondly, to identify the competencies they needed to give this support.

The data from the surveys were subjected to simple descriptive statistical analysis. These analyses reveal that therapists have a very wide range of roles relating to direct support, including: assessment, intervention with individual learners and learners in groups, and evaluation. Interventions include the development of hearing, speech and communication skills; skills for activities of daily living; life skills; home management skills; work related skills; motor function skills; and play and leisure skills. Therapists from different disciplines frequently provide the same type of support. Indirect support provided includes support for the schools system, teachers and parents. Thirty six percent of the therapists in this study want to increase the proportion of time they spent on indirect support. The study also revealed that multidisciplinary collaboration and teamwork were poorly developed.

Teachers involved in the study identified that they need an enormous amount of support in fulfilling their crucial roles in identifying barriers to learning; identifying the support learners need; and addressing the barriers. This includes the need for support to teach a diverse group of learners; adapting content, presentation and evaluation of the curriculum; adapting the physical environment; accepting new roles of teachers and therapists; making changes to the school system; developing relationships with the parents; addressing challenges related to socio-economic problems; networking with the community; facilitating positive attitudes to diversity; developing supportive relationships with therapists; and further training.

Parents in this study indicated that they need access to education and support for their children, including direct support for their children; effective means of communicating with their children; specific competencies to facilitate caring for their children; emotional support; advocates to work with them in support of their children addressing environmental physical and attitudinal barriers, and developing a supportive community; and supportive relationships with therapists.

Therapists identified the curriculum as the focus of their support for teachers. Support needs to become integrated into the curriculum and not additional to it. They highlighted the importance of their relationships with the teachers. Therapists emphasised their need to increase support for the parents. Unlike indirect support, they are confident in their abilities to provide effective direct support and want to continue to provide it. Therapists need further training in the competencies identified and mentoring for their own well-being.

The implementation of an inclusive education policy in schools located in communities experiencing enormous socio-economic problems is a major challenge in South Africa. Individually, therapists feel that they cannot give effective support to the school system. The development of the multidisciplinary district-based support teams along with good multisectoral collaboration within each education district is imperative. This thesis argues that using the approach of building health promoting schools would be a holistic way to provide support to the school system, including all learners, teachers and parents. The competencies that therapists require to provide this support are identified. The thesis concludes with the recommendation that an action-reflection approach be used in the training of therapists and that this training includes all members of the district-based support team.

November 2005

DECLARATION

I declare that *The role of occupational therapy, physiotherapy and speech and language therapy in education support services in South Africa* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Name: Patricia Mary Struthers Date:

Signed: ……..

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LIST OF ABBREVIATIONS

DBST	District-based Support Teams
DICAG	Disabled Children's Action Group
EMDC	Education Management and Development Centre
IEP	Individualised educational programme
NCSNET/NCESS	National Commission on Special Needs in Education and Training and National Committee on Education Support Services
RNCS	Revised National Curriculum Statement
UNICEF	United Nations Children's Education Fund
WCED	Western Cape Education Department
WHO	World Health Organisation

TERMINOLOGY

Barriers to learning	The notion refers to difficulties that arise within the education system as a whole, the learning site and/or within the learner him/herself which prevent both the system and the learner needs from being met. (Department of Education, 2005).
deaf or Deaf	The term Deaf is to indicate the membership of the Deaf community, an alliance of a cultural and linguistic minority. The term deaf is used to indicate the impairment (DEAFSA).
District-based support teams (DBST)	Groups of departmental employees whose job it is to promote inclusive education through training, curriculum delivery, distribution of resources, identifying and addressing barriers to learning, leadership and general management (Department of Education, 2005).
Education support services	Support services include support from within the school, as well as to schools. Personnel include occupational therapists, physiotherapists, speech and language therapists (Department of Education, 1997).
Full-service schools (FSS)	Ordinary schools which are specially equipped to address a full range of barriers to learning in an inclusive education setting. In addition to their ordinary learner population they will become accessible to most learners in an area who experience barriers to learning and provide the necessary support. In the initial implementation stages these full service schools will be models of institutional change which reflect effective inclusive cultures, policies and practices (Department of Education, 2005).
Ordinary local schools	In terms of the South African Schools Act (1996) a public school may be an ordinary public school or a public school for learners with special education needs (Section 12(3)). The local ordinary school would be the school closest to where the learner lives (Department of Education, 2005).

PART ONE

BACKGROUND

CHAPTER ONE

INTRODUCTION

The theme of my thesis is the education support service required to support the development of an inclusive education system. The focus of this study is on the changing roles of occupational therapists, physiotherapists, and speech and language therapists, jointly referred to as therapists, in schools in South Africa. The study highlights the competencies therapists require to provide appropriate support for the implementation of an inclusive education system.

The desire to explore and learn is fundamental to our development, though opportunities for learning and development are, in part, dependent on the structure of the society we live in. The education system of a society has the responsibility to provide a structure and organisation for learning to take place.

In my research I investigated the therapists' roles in supporting the learning process through their direct support of school-aged learners experiencing barriers to learning and their indirect support of teachers, parents and the broader school system. I explored their roles in promoting the health of all in the school community through the development of health promoting schools to ensure that effective learning takes place.

1.1 RATIONALE

The international struggle to ensure human rights for all and a respect for diversity forms the background to this research. Integral to this have been demands for equal opportunities for all, including education for all (United Nations, 1948, 1989, 1993a, 1993b). Within this context, in 1994, the Salamanca Declaration proposed that all governments adopt laws, or policies, on inclusive education (UNESCO, 1994). Despite debates and different interpretations of inclusive education, it can be described as a process where diverse learning needs are accommodated in a single education and

training system (Howell, 2000). It is a process aimed at improving schooling and overcoming exclusion (UNESCO, 1999).

To ensure equal opportunities for all in South Africa, policy has being developed to enable all learners to be educated through the development of an inclusive education and training system (Department of Education, 1997, 1999, 2001). Implementation of the policy is the challenge now facing South Africans, as large numbers of learners experience barriers to learning and development (Department of Education, 2001, 2003a, 2003b). Appropriate support from various people, including therapists, is needed to address these barriers (Department of Education, 1997, 2001, 2003a).

The Department of Education has identified the need for the roles and the functions of personnel who provide education support to schools to be transformed to provide support for the school system, including support for whole-school development and development of the curriculum (Department of Education, 1997, 2001, 2003a). Support needs to be given to teachers and parents to enable them to identify barriers to learning and to develop appropriate interventions. Preventive and promotive programmes, using health promoting strategies, need to be developed. Support includes directly addressing barriers to learning and development through appropriate interventions if the teachers and institution-level support teams have not been able to provide a solution.

1.2 MY BACKGROUND

I am aware that in the course of this study my own role, as the researcher may have affected the findings. This is discussed in Section 4.1.2.2 of this thesis. I acknowledge that gathering and interpreting the data, including identifying the themes that emerged, cannot be uncoupled from who I am and my personal history, which I describe briefly below.

I am an English-speaking, white, middle-class, middle-aged South African woman. I am trained as a physiotherapist.

My concern for human rights and the recognition of the need for fundamental political change in South Africa long preceded my recognition of the radical changes that would be needed for inclusive education to become a reality for all in South Africa. I believed in and supported the vision of a democratic, socialist South Africa.

For a period of time I supported the concept of special schools, where children with disabilities might at least have the opportunity to get some education. My own work with children with disabilities started in 1978 while I was working as a clinical physiotherapist at a former mission hospital, Glen Grey Hospital, in the former Transkei, now the Eastern Cape. An outbreak of poliomyelitis in the area resulted in large numbers of children becoming paralysed. I was challenged to think beyond my narrow "world of health care" to education as I became aware of the need for the older children to attend school.

Subsequently, I became involved in a closer link between health and education while I was employed as a physiotherapist at Baragwanath Hospital in 1980. I was based at the cerebral palsy clinic where, as part of a team, I was involved in the assessment of children who attended the clinic to identify which children would be accepted at the new Phillip Kushlik Special School. Throughout this period my view was that attending a special school would give children with disabilities an opportunity to learn that they would not otherwise have. It seemed appropriate for me, a physiotherapist, to be involved in the assessment for admission as I could assess their motor abilities. I did not consider the need for teachers to be involved in this assessment process. Parents were only marginally involved. I was not in any way involved in the inclusion of learners with disabilities in ordinary schools.

Between 1982 and 1985 I lived in Zimbabwe and was employed as a physiotherapist at Jairos Jiri School, a special school in Harare for learners with physical disabilities. During this time I became involved in a project to help integrate some of the learners, from the special school, into their local schools. For several weeks a year the rehabilitation assistants from Jairos Jiri School travelled around the country to determine if it was feasible for the learners from the special school to get to the local schools from

their homes. I became increasingly aware of the possibility of including learners with physical disabilities in ordinary schools.

Then in 1985 I moved to Britain where, for six years, I was employed by the National Health Service in inner city London to work as a paediatric community physiotherapist. The work included working with children at home, at ordinary schools and nurseries, and at special schools and nurseries. It was during this period that I had the experience of working within an education system that had a policy of inclusion. As an example I will tell the story of a young girl with a severe physical disability. Rachael[1], a four years old girl, was from an Orthodox Hassidic Jewish family. Initially I saw her at home. However, when the time came for her to attend school her parents could not agree with the decision made by the education and health authorities that she should attend a special school. In her parents' opinion, it was important that she attend the community's religious school and become a part of the community. Through a process of identifying the support that Rachael needed, and negotiating how this could be made available, a decision was reached to enable her to attend the special school for part of the week, with the remainder of the time at the Jewish school, until such time that she was able to attend the Jewish school full time. It was a valuable experience for me having the opportunity to work in a partnership with parents facilitating effective inclusion.

The final significant experience that I describe was from 1992 to 1997 when I was employed as a physiotherapist by the Western Cape Education Department working at Eros Special School for children with cerebral palsy, in Cape Town. It was a time of political change accompanied by the development of new policy. I saw learners who would not otherwise receive an education being included in the school. However, there were many learners with whom I worked, including learners with severe disabilities, who spoke of how they wished they could attend ordinary schools. There was the four-year old little girl from a farm in Namaqualand who would cry herself to sleep every night because she was so far from home. I grew to believe inclusion in their local ordinary

[1] Name changed

school was an option many of the learners should be given. I questioned whether what I was doing at the special school was the most appropriate way of providing support.

During this period, while doing a Masters in Public Health at the University of the Western Cape, I conducted a small qualitative study to identify the views of therapists on inclusive education (Struthers, 1997). The findings indicated that, although there was support for a policy of inclusion, therapists were not clear on what their role would be. In addition, I became aware of how the implementation of inclusive education needed a complete shift from a medical to a social model of support. Most significantly, I realised that change needed to involve the education system as a whole as that was where the major barriers to learning were.

It was at this time that I learnt of health promoting schools and became interested in their role in changing the education system to promote inclusion. Subsequently, with my move to work at the University of the Western Cape, I became involved in a forum, at the university, for health promoting schools. Finally, I have had the invaluable opportunity, over the past few years, of being a member of the national Department of Education's Working Group on Screening, Identification, Assessment and Support involving the development of tools to facilitate the implementation of an inclusive education system.

1.3 THEORETICAL FRAMEWORK

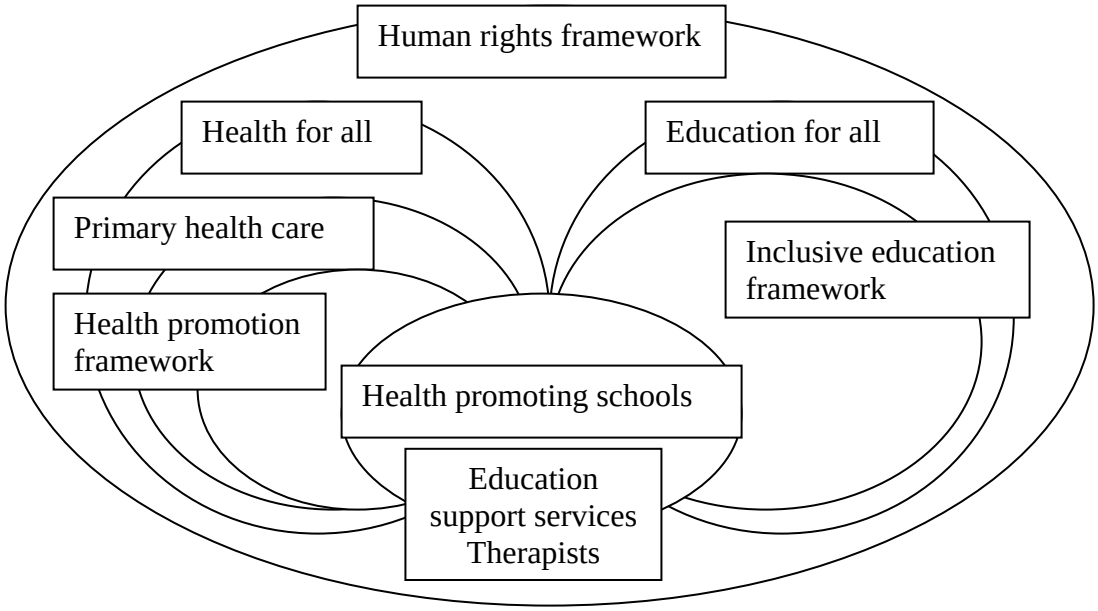
An inclusive education framework and a health promoting schools framework form the theoretical framework of this research.

In many countries, including South Africa, education support services for learners at school have, in the past, focused on assessing and treating individual learners who have been identified as having "special needs" (Department of Education, 1997). The move to an inclusive education system has led to a change in the way support is provided both internationally and locally. There has been acknowledgement that support is needed for the whole school system, not only selected individual learners. The support needs to focus on preventing the development of barriers to learning, focusing on whole-school

development. This involves a change in the way support is provided from direct support for learners to indirect support for the education system: “This has resulted in moves towards a more indirect, consultative approach to service delivery focusing on educator and parent training, institutional development strategies and greater involvement of centre-of-learning and community-based strategies” (Department of Education, 1997: 100).

My interest lies in how learners can be included most effectively in schools. My view is that education at school needs to be a rich and creative learning experience where diverse learners can interact with one another and with teachers with different skills and interests; and that this learning opportunity will best prepare the learners for the broader communities they come from. I suggest that an inclusive and health promoting school environment would be the most appropriate setting for this to develop in. Health promoting schools are considered effective settings for the promotion of the health of the learners, the teachers, the broader school community, the parents and the broader community. I explore the possibility for therapists, within the district-based support team, to play a creative supportive role in developing inclusive schools within the health promoting schools framework. This framework is illustrated in Figure 1.1.

Figure 1.1: Theoretical framework - health promotion and inclusive education



1.4 RESEARCH QUESTIONS, RESEARCH AIM AND METHODOLOGY

Two key research questions were identified for the research:

1. What is the most appropriate way for therapists to provide support services for schools in South Africa?

2. What competencies do therapists need to support schools in South Africa?

The aim of this research was to develop an appropriate and integrated approach for therapists to support schools within an inclusive and health promoting schools framework in South Africa.

Participatory action research, using a quantitative and qualitative methodology was used in this study to answer the research questions. It included the use of surveys, focus group

discussions and workshops. While the surveys included all therapists in the Western Cape Province the focus group discussions with the teachers and parents and the workshops with the therapists were conducted in two of the seven education districts. The participatory approach with the therapists started early in the process of the study and continued throughout. The study was viewed as the first phase of this ongoing action research with the therapists that will continue after the completion of this study. This is discussed in Section 4.2.2 (see Figure 4.1) and Section 10.3.

1.5 CONTRIBUTION OF STUDY/SIGNIFICANCE OF STUDY

The study makes a distinct contribution to the development of the education support services in South Africa. It makes a practical contribution to the Department of Education and the training institutions, firstly, by identifying the roles and responsibilities of therapists that schools and parents need for effective support, and, secondly, the competencies that therapists need to provide this support. Additionally it strengthens and extends the theoretical frameworks of health promoting schools and inclusive education through linking them and demonstrating how therapists can provide holistic support to building inclusive schools using the health promoting schools framework.

1.6 OUTLINE OF CHAPTERS

My thesis is organised into three parts comprising ten chapters. Part One provides the background information. This part includes Chapter One, the introduction to the thesis, and Chapters Two and Three, the literature review. The literature providing the background to health promotion and therapy support is presented first, followed by the literature on inclusive education, as therapists work in an education setting. Links between the two chapters are made through the health promoting schools framework and its relationship to the inclusive education framework which provides the theoretical framework for this research (illustrated in Figure 1.1). Part Two includes the details of the research: the research method used in the study and the research findings. The research method is presented in Chapter Four. As the findings are extensive they are divided into four chapters: Chapter Five presents the current roles of the therapists; Chapter Six presents the teachers' needs for support from therapists; Chapter Seven

presents the parents' needs for support from therapists; and Chapter Eight presents the findings from participatory research with the therapists. Part Three is divided into two chapters. Chapter Nine synthesises and discusses the findings in relation to the literature. Chapter Ten presents the conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW: PRIMARY HEALTH CARE AND THE EMERGENCE OF A HEALTH PROMOTION FRAMEWORK

This chapter reviews the literature on health and health promotion and makes the link with inclusive education through the review of the literature on health promoting schools. This provides the background to the research which aims "to develop an appropriate and integrated approach for therapists to support schools within an inclusive and health promoting schools framework in South Africa".

The literature search was conducted both manually and electronically. The manual search included all occupational therapy, physiotherapy and speech and language journals available in the Western Cape dating back to the changes in education policy in the USA and Britain. Extensive searches of electronic journals were also conducted. Leading therapists in the USA including Anita Bundy, Mary Law, Jane Case-Smith and Gillian King were personally contacted to identify additional literature related to support provided by therapists. Carolyn Simmonds Carlson assisted with literature from New Zealand. Key words used in searching the literature included: occupational therapy; physiotherapy; physical therapy; speech and language therapy; speech therapy; primary health care; health promotion; health promoting schools; schools; education; inclusive education; education support services; teachers; educators; parents; participatory action research; action research; South Africa; intersectoral collaboration; multisectoral collaboration; partnership; and disability.

2.1 HEALTH

In this section, I will start by looking at how the concept of health has been affected by development changes in political and social structures globally and in individual countries.

There are many interpretations of the term "health". In 1948, to avoid a limited biomedical definition of health, the World Health Organisation defined it as "A state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (WHO, 1946). This definition was reaffirmed in the World Health Organisation-United Nations Children's Education Fund (WHO-UNICEF) Alma Ata Declaration in 1978 (WHO, 1978). The holistic nature of the definition has facilitated the movement of health activity beyond disease prevention in an attempt to promote "well-being" (Baum, 1998). Additionally, in South Africa a reference to spiritual health is sometimes also included in the definition of health: "All aspects of life impact on one's health and well-being, including physical, mental, social, environmental, economic, and spiritual aspects" (Department of Health, 2000). Identifying magical or spiritual determinants of health and disease is common in the belief systems of indigenous people and in the lay person's definition of health but ignored in the medical model (Baum, 1998).

The post Second World War period from 1948 through to the Alma Ata Declaration on Primary Health Care in 1978 brought many political changes internationally. It was a time when the politics of health and health care were brought into the open. Changes led to a focus on the link between health and development, "the process of improving the quality of all aspects of human life" (WHO as cited in Phillips & Verhasselt, 1994: 4). The 1950's and 1960's were identified as a period in which modernisation theories related to development promoted investment in physical structures including industry, roads and building dams rather than on social development through empowerment (Phillips & Verhasselt, 1994; Walt & Vaughan, 1981). This was reflected in the physical structures that were built to address health problems including sophisticated hospitals. The underlying assumption was that a capitalist or mixed economy was needed to bridge

the gap between rich and poor, and that "developing countries were as yet unformed infant versions of modern Western societies" (Walt & Vaughan, 1981: 3). However, the gap between the rich and poor in developing countries continued to grow (Harrison, 1983).

The modernisation theory was criticised by proponents of the dependency theory. They emphasised that it was, firstly, the nature of the relationship between the state and the economy, and, secondly, the relationship between local and global economies that determined development or underdevelopment of countries, and uneven development within countries (Brandt, 1980; Phillips & Verhasselt, 1994; Sanders & Carver, 1985). Between 1950 and 1970 a change in attitude towards inequalities between social groups took place. Harrison (1983: 25) describes how there was a "… groundswell of disenchantment with growth in the West … (which) formed the background to the new approach to thinking about development which began in the early seventies". There was a call for social justice and for essential basic public services, including health and education services, by developing countries (Harrison, 1983). New models of development focused on the need for redistribution of wealth from rich to poor countries and a reduction in inequality. Simultaneously there was increasing recognition of inequalities in health care which existed between countries and within countries where the urban elite consumed health service resources at the expense of the poorer rural majority (Walt & Vaughan, 1981).

In addition, in the 1960's, concern was expressed about the Western model of medical care. Although there had been some successes in tackling diseases such as smallpox, many other problems, for example malnutrition, needed social, educational, economic and political solutions rather than medical interventions (King as cited in Walt & Vaughan, 1981). Health care, with its focus on curative care, was described by Sanders and Carver (1985) as inappropriate. They stated that the social and economic determinants of health were the main causes of illness, particularly in developing countries. The medical technology being utilised was described as expensive and inappropriate. Illich (as cited in Walt & Vaughan, 1981) criticised medical interventions

and the use of pharmaceuticals alleging they were making illness worse. Djukanovic & Mach (1975) argued that basic health services needed to be "available", "accessible", "acceptable" and "appropriate". There was increasing concern that individualised interventions rather than population based interventions had become prioritised with the adoption of the Western medical model.

> The transplantation to the underdeveloped world of this Western medical approach was part of the more general process of the extension of the capitalist system. Medicine was just one of many commodities now circulating in the dominant sectors of the economies of underdeveloped countries. This resulted in the neglect of health promotion, the stunting and individualisation of preventive care, the overdevelopment of curative medicine and also in the gross maldistribution of these inappropriate services. (Sanders & Carver, 1985: 135)

Simultaneously, however, there was increasing recognition of the value of community based health programmes (Newell, 1973). Examples of the model of health care adopted by China indicated the importance of involving communities in their own health care (Walt & Vaughan, 1981). Community participation using a "bottom-up" approach was emphasised. "Participation should occur at each stage of the development process: before, during and after. In setting the goals and making the decisions that affect the community; in carrying out the plans; and sharing the benefits" (Harrison, 1983: 36).

In summary, health is identified as a broad holistic concept, and health care provision is related to the country's political and economic structure. Internationally, the influence of capitalism and a Western biomedical approach, which largely ignored health promotion, led to inappropriate and inequitable health care both within and between countries. Nevertheless, different models of health care emerged emphasising the need for primary health care and community participation, which is described below.

2.2 PRIMARY HEALTH CARE

In 1975 Mahler, the Director General of WHO, launched the concept of "Health for All by the Year 2000" (Tones & Tilford, 2001). The strategy for reaching this goal was to be primary health care. An international meeting to get joint agreement on these ideas was

organised by WHO and UNICEF in Alma Ata, USSR in 1978 and led to the Alma Ata Declaration (WHO, 1978). This Declaration was the result of the political changes that had been taking place internationally, and increasing concern about social inequity and its impact on health. The Declaration states that countries need to base their health systems on primary health care with the emphasis on health promotion and disease prevention strategies. The goal that was set by WHO-UNICEF was to achieve "… a level of health that will permit [all peoples of the world] to lead a socially and economically productive life" by the year 2000 (WHO, 1978: Article V).

Primary health care involves a comprehensive approach. The five basic principles of the primary health care approach are: equitable distribution of services; community involvement; a focus on prevention and promotion rather than curative care; use of appropriate technology; and using a multisectoral approach (Walt & Vaughan, 1981). "Primary health care … addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services" (WHO, 1978): Article VII, 2). The focus is on achieving equity in health status by addressing the underlying social, economic and political determinants of health, and promoting "a more equitable distribution of resources" (Werner & Sanders, 1997: 18).

Implementation of the comprehensive primary health care approach has rarely happened and an equitable distribution of health services has not taken place (Asthana, 1994; Sanders, 1998; Sanders & Carver, 1985; Werner & Sanders, 1997). Political and economic pressures globally including recession, debt, and structural adjustment policies in the 1980s forced developing countries to become more market orientated and even less equitable. Primary health care in many developing countries involved its integration into a "top-down", hierarchical model and a move to selective primary health care, excluding, amongst other things, integrated community-based health programmes requiring multisectoral action. While the radical language of Alma Ata continued with rhetoric of community participation and empowerment, with some training of community health workers, comprehensive primary health care was undermined and health care became

institutionalised (Werner & Sanders, 1997). The focus on addressing the underlying social, economic and political determinants of health was ignored.

Walsh and Warren of the Rockefeller Foundation (1979) argued that the goal set at Alma Ata of a comprehensive primary health care approach was "above reproach, yet its very scope makes it unattainable" (Walsh & Warren, 1979: 967). Their view was that because of limited financial and human resources, there was a need for "…selective primary health care directed at preventing or treating the few diseases that are responsible for the greatest mortality and morbidity in less developed areas and for which interventions of proven efficacy exist" (Walsh & Warren, 1979: 967). They recommended that governments select a "package" of health interventions. Four factors, including prevalence, morbidity, mortality and feasibility of control (including efficacy and cost) would be used to identify which health problems would be selected for prevention and treatment.

Shortly afterwards, the 1982-83 UNICEF report identified and operationalised a package of interventions for children referred to as "GOBI" (Sanders, 1998): Growth monitoring, oral rehydration therapy for diarrhoea, breast feeding, and immunization. Later "fertility control/family planning", "female literacy", and "food" (Lovel, 1989) were added and it was now referred to as "GOBI-FFF". This approach of UNICEF began to define global health policy with many other international, bilateral and donor agencies and NGOs following in its footsteps. According to J. Cohen (Advisor on Health Policy, Director-General's Office, WHO, personal communication September 30, 2004) the fragmented elements of primary health care were subsequently imposed on developing countries.

Wisner (Wisner, 1988) criticised the development of selective primary health care, pointing out how nothing was included in the package supporting empowerment or community participation. His view was that the package undermined the struggle for health rights: "UNICEF locates health action wholly outside the realm of socio-economic rights and responsibilities" (Wisner, 1988: 965). Subsequently, in 1993 the World Bank also recommended a "package" of essential clinical services together with specific basic

public health interventions, which were regarded as cost-effective, further supporting the selective primary health care approach (World Bank, 1993).

Implementation of the goals of Alma Ata required radical political and economic shifts. This was a commitment most governments were unwilling to make, particularly with the political conservatism of the 1980's (Sanders, 1998; Sanders & Carver, 1985; Werner & Sanders, 1997). As Werner and Sanders argue: "[Selective primary health care] stripped primary health care of many of its key concepts. The emphasis on overall social and economic development was removed, as was the need to include all other sectors that related to health in the focus of the programs" (Werner & Sanders, 1997: 23).

Supporters of a comprehensive primary health care approach viewed community development, adequate and appropriate housing, education and nutrition as essential to health. "The narrow technicist focus characterising what has been termed the selective PHC (primary health care) approach has at best delayed, and at worst undermined, the implementation of the comprehensive strategy codified at Alma Ata" (Sanders, 1998: 57).

Comprehensive primary health care includes curative care, rehabilitative care, disease prevention and health promotion (WHO, 1978). However, these four aspects of health care have often been developed in isolation from each other. As Sanders highlights, in many health systems primary health care and health promotion have operated in parallel and not in a unified way.

> The PHC initiative has too often focused only on the (often facility-based) curative and preventive components of comprehensive care, while the health promotion movement has stressed the broader social components. The divide between these two initiatives needs urgently to be bridged since they are clearly indivisible in the process of health development. (Sanders, 1998: 67)

In summary, the development of comprehensive primary health care was derailed by the move to selective primary health care. There was a fragmented approach to the provision of curative care, rehabilitation, disease prevention and health promotion. In the wake of

this health promotion emerged, emphasising the need to address the social determinants of health and the need for community empowerment.

2.3 "PROMOTIVE" COMPONENT OF PRIMARY HEALTH CARE

The roots of health promotion can be found in the 1946 WHO definition of health (WHO, 1946), the WHO call for Health for All by the year 2000 (Mahler cited in Tones & Tilford, 2001) and the Alma Ata Declaration (WHO, 1978). In 1984 a new WHO programme on "Health Promotion" was set up with health promotion defined as: "The process of enabling people to increase control over, and to improve, their health" (WHO, 1984). This was changed in 1998 to reflect the underlying determinants of health: "Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health" (WHO, 1998a). In 1986, Kickbusch described health promotion as "… a new forcefield for health [which] integrates social action, health advocacy and public policy" (Kickbusch as cited in Tones & Tilford, 2001: 21). In addition the need for multisectoral action was stressed. It could be argued that this development of health promotion was a return to the principles of the Alma Ata Declaration. There was a focus on aspects of comprehensive primary health care including community involvement and a multisectoral approach to health that had been ignored by many governments with their support of selective primary health care.

The 1970's had brought the "discovery" in developed countries that individual lifestyle could have an impact on health (Baum, 1998). The advocates of lifestyle modification gained the support of conservative Western governments in the early 1980's and state-wide health promotion programmes which focused on a behavioural approach to health promotion were set up in Australia, Britain and the USA (Baum, 1998; Tones & Tilford, 2001). Baum (1998) describes how this led to a range of health promotion approaches to try to change behaviour and individual lifestyles through the development of health promotion models based purely on psychological theory with minimal recognition of social factors affecting health. These early models of behaviour change were based on the assumption that there is a close link between knowledge, attitudes and behaviour. The

assumption was that increased knowledge would lead to attitude change followed by behaviour change (Baum, 1998). These models, described in detail by Baum (1998), included the health belief model which was developed by Becker in 1974; the theory of reasoned action developed by Ajzen and Fishbein in 1980; social learning theory developed by Bandura in 1977; and stages of change model developed by Prochaska and DiClemente in 1984. As a result large-scale health promotion campaigns were undertaken in developed countries to control risk factors by changing behaviour.

2.3.1 Health promotion and disease prevention

The difference between health promotion and disease prevention is most often brought into question in relation to the medical and behavioural approaches. Are health promotion interventions that use a medical or behavioural approach health promotion or disease prevention? Is prevention a part of health promotion or separate from it, or do they overlap? Baum (1998) and Tones and Tilford (2001) argue that medical approaches to health promotion concentrate on the prevention of disease. This is similar to the WHO definition of prevention:

> Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation. (WHO, 1998b: 4)

Primary disease prevention is associated with the prevention of risk behaviours amongst individuals or in a population. The WHO glossary expands the original definition of risk behaviours which focused on the association to a specific disease:

> Risk behaviours are usually defined as “risky” on the basis of epidemiological or other social data. Changes in risk behaviour are major goals of disease prevention, and traditionally health education has been used to achieve these goals. Within the broader framework of health promotion, risk behaviour may be seen as a response, or mechanism for coping with adverse living conditions. Strategies to respond to this include the development of life skills, and creation of more supportive environments for health. (WHO, 1998b: 4)

Prevention may thus be seen as a health promotion activity attempting to change "risky" behaviour through the use of various health promotion strategies that develop or empower the individual and result in socio-environmental changes. There is evidence that addressing individual risk factors and attempts to change behaviour are unlikely to succeed unless the socio-environmental factors are supportive. The leading risk factors associated with risk behaviour identified in the World Health Report 2002 include underweight, unsafe sex, tobacco consumption, alcohol consumption, unsafe drinking water, sanitation and hygiene and obesity (WHO, 2002). They need to be addressed within a comprehensive health promotion programme.

While some authors emphasise disease prevention activities in health promotion interventions, others emphasise the need for empowerment and social change to be present in health promotive interventions. McDonald and Davies (as cited in Raphael, 2000: 357), argue: "If the activity under consideration is not enabling and empowering it is not health-promotion". This holistic approach identifying the need to address social determinants of health is the approach I take in this research.

2.3.2 Health promotion and social determinants of health

The First International Conference on Health Promotion in 1986, which gave rise to the Ottawa Charter, was built on earlier social and health movements (Baum, 1998). There was a return to a holistic view of the social determinants of health, "… peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity" (WHO, 1986: 13). The Charter integrated the approaches of changing the socio-economic system with changing behaviour and lifestyle. It defined health promotion as,

> … the process of enabling people to increase control over and to improve their health …. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capabilities. (WHO, 1986: 13)

Subsequently the determinants beyond the individual became emphasised. In 1998 WHO described health promotion as addressing the full range of personal, social, economic and

environmental determinants of health that affect individuals and populations, including factors beyond the control of individuals and groups (WHO, 1998a). This holistic view reflects that of comprehensive primary health care.

Five broad areas or strategies for action are identified in the Ottawa Charter (WHO, 1986):

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

Like comprehensive primary health care, the Ottawa Charter emphasises the need to strengthen community action: "At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies" (WHO, 1986: 14). Subsequent international health promotion conferences reaffirmed the Ottawa Charter's five strategies for action but emphasised the need to combine the different strategies in interventions. As the Jakarta Declaration (WHO, 1997) states: "There is now clear evidence that comprehensive approaches to health development are the most effective. Those that use combinations of the five strategies are more effective than single track approaches" (WHO, 1997). The Ottawa Charter further recommends using "advocacy", "enablement" and "mediation", and the Jakarta Declaration emphasises the need for an empowering process:

> Health promotion is carried out by and with people, not on or to people. It improves both the ability of individuals to take action, and the capacity of groups, organizations or communities to influence the determinants of health. (WHO, 1997)

The need for participation through developing partnerships at all levels of society is considered essential to health promotion. "Each partnership must be transparent and accountable and be based on agreed ethical principles, mutual understanding and respect" (WHO, 1997). This has been reaffirmed at subsequent international health promotion conferences, including the Sixth International Health Promotion Conference in Bangkok

(WHO, 2005) which emphasises the development of partnerships, including partnerships with the private sector. However, it is important to be critical of the assumption that the private sector can play a significant role in addressing the social determinants of health and a move towards equity. Although a corporation may on occasion support a project addressing inequity, the fundamental economic principles related to making profits underlying capitalism contradict the ability of the large corporations to bring about equity. Fundamental political change is needed to address the social determinants and bring about social equity.

2.3.3 Health promotion and the settings approach

The link between health and the setting in which we live was made at the First International Conference on Health Promotion in Ottawa in 1986 and acknowledged in the Ottawa Charter:

> Health is created and lived by people within the settings of their everyday life; where they can learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow that attainment of health by all its members. (WHO, 1986)

Creating environments that promote health was the focus of the Third International Conference on Health Promotion: Supportive Environments for Health (WHO, 1991b). Reports from this conference present a broad holistic understanding of both the physical and social aspects of the environment. The environment includes the local community, the home, the place where people work, go to school or play. Creating supportive environments needs to encompass and interlink physical, spiritual, economic and political dimensions.

Subsequently, at the Fourth International Health Promotion Conference, following the evaluation of health promotion interventions internationally, the value and effectiveness of including the whole setting, including hospitals, cities and schools, in a health promotion intervention was emphasised in the Jakarta Declaration (WHO, 1997). It states

that interventions need to be comprehensive, use whole settings, involve participation of all stakeholders and include the provision of information.

> There is now clear evidence that
>
> - Comprehensive approaches to health development are the most effective. Those which use combinations of the five strategies are more effective than single track approaches.
> - Settings offer practical opportunities for the implementation of comprehensive strategies. These include mega-cities, islands, cities, municipalities, and local communities, markets, schools, workplace, and health care facilities.
> - Participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for it to be effective.
> - Health learning fosters participation. Access to education and information is essential to achieving effective participation and the empowerment of people and communities. (WHO, 1997)

The Jakarta Declaration went on to state:

> "Settings for health" represent the organizational base of the infrastructure required for health promotion. New health challenges mean that new and diverse networks need to be created to achieve intersectoral collaboration. Such networks should provide mutual assistance within and between countries and facilitate exchange of information on which strategies are effective in which settings. (WHO, 1997)

Multisectoral collaboration is considered essential to working in settings. Health promoting schools and the collaboration between health and education sectors is discussed in depth in Section 2.5.

2.3.4 Health promotion approaches

The term "health promotion" continues to have different interpretations. A framework outlining three different approaches to health promotion is provided by Labonte (as cited in Baum, 1998). These include a "medical approach", a "behavioural approach" and a "socio-environmental approach":

> … the medical approach that tries to return sick people to a disease-free state; the behavioural approach that promotes healthy lifestyles; and the socio-environmental approach that is concerned with the totality of health experiences and the factors that help to maintain health, including those connected directly with people (behaviour, self-esteem and genes) and environment (income, housing, employment). (Labonte as cited in Baum, 1998: 290)

Labonte describes the medical and behavioural approaches as limited and needing to be complemented with the socio-environmental approach. Baum supports this view: "Programs that focus on individual behaviour change have been widely criticized for ignoring the lack of opportunities for disadvantaged people to be healthy" (Baum, 1998: 35). A similar position is taken by the World Health Organisation in the report: "A call for Action: Promoting Health in Developing Countries", which highlights the need for health promotion programmes to focus on social change: "The focus of health promotion is *social action* for health. It seeks to create and continually reinforce conditions that enable people to make wise health choices and encourage them to live healthy lives" (WHO, 1991a: 5).

Baum criticises the individualist behavioural approach and the social psychology theories which focus on the individual making and taking responsibility for choices while ignoring environmental and social factors and the effect of poverty on health. "The individualist focus of most behavioural health promotion creates an undercurrent of victim blaming, which maintains that individuals are responsible for their own health status, whatever their social and economic circumstances" (Baum, 1998: 316). Raphael (2000) states that the medical and behavioural approaches, with their focus on risk factors and the use of social psychology theories, are most commonly used by health professionals who focus on disease and view health as the absence of mortality and morbidity (Raphael, 2000). Baum, citing the need for social justice and respect for the rights of the individual, is strongly critical of how health professionals have used the behavioural approach:

> Victim-blaming approaches to health promotion sit well with health professionals whose main training, skills and techniques are based on individualistic

> perspectives such as psychologists, doctors, speech pathologists and physiotherapists. (Baum 1998: 76)

She continues,

> The poor believe they are in difficult situations because of their lack of merit and worth in a society that assumes success can be put down entirely to individual effort. Thus, persuasive victim blaming contributes to low self-esteem, which in turn contributes to poor health. (Baum, 1998: 76)

The assumption underlying these behavioural models is that it is primarily the provision of support and information to individuals and not environmental change that will lead to behaviour change. The models do not combine the individual approach with facilitation of collective action to change social or systemic causes of the problem.

The different approaches to health promotion and this division in health promotion have been compared to the division in primary health care: "… the debate between selective and comprehensive primary health care mirrors that in industrialised countries about approaches to health promotion" (Baum, 1998: 35). As in comprehensive primary health care, the importance of community involvement and empowerment is considered a key area of action in health promotion by people using the socio-environmental approach.

2.3.5 Community empowerment and social capital

> Community empowerment, which we more specifically define as shifts towards greater equality in the social relations of power (who has the resources, authority, legitimacy or influence), is an unavoidable feature of any health promotion effort. It arises as an effect of which health issues are "targeted" for action, how resources are allocated, what strategies are selected and, most importantly which stakeholders retain or share authority over these decisions.
> (Laverack & Labonte, 2000: 255)

Community empowerment requires community participation, which Zakus and Lysak define as "a strategy that provides people with the sense that they can solve problems through careful reflection and collective action" (Zakus & Lysack, 1998: 2). This has challenged the approach of many health workers who see themselves as the experts and

are used to a “top-down” rather than a “bottom-up” approach. Laverack (2000) argues that only a “bottom-up” approach can bring about improvement in power or capacity. The “top-down” approach is associated with disease prevention, with improvement in behaviour considered the desired outcome.

The concepts of “community”, in health promotion, have undergone development since the 1990’s with increasing emphasis being placed on the importance of “social capital”. Social capital, a term describing the existence of trust in relationships in a community, originated in general sociology but this concept became increasingly popular in the 1990’s in health promotion literature (Baum & Ziersch, 2003; Edmondson, 2003; Hawe & Shiell, 2000; Looman & Lindeke, 2004). Cox (as cited in Baum, 1998: 94) defines social capital as: “the processes between people which establish networks, norms, social trust and facilitate coordination and cooperation for mutual benefit”. Or as Gillies explains it:

> Generally social capital is produced by features of the organisation of our societies and communities, which facilitate coordination, co-operation and reciprocity. Therefore many overlapping and diverse horizontal networks for communication and exchange of information, ideas and practical help will exist where stocks of social capital are high. The relationships and friendships among adults, which form the bedrock of social networks, provide an informal structure upon which formal citizenship and civic engagement is built. (Gillies as cited in Tones & Tilford, 2001: 406)

Reid (as cited in Baum, 1998: 94) adds that in addition to consisting of trust and respect, social capital reflects “the creation of alliances across differences”. Onyx (as cited in Baum, 1998: 96) defines the key elements of social capital as: “valuing self and others; trust (interpersonal and generic); connection: participation and networking; multiple relationships; and reciprocity in relationships”.

Baum argues that evidence of a link between social capital and health has important implications for health promotion. She argues that health promotion firstly needs to provide “opportunities for people to come together and establish networks and trust”. Secondly, health promotion needs to focus on “the nature and quality of interactions

between people rather than on individual behaviour or risk factors" (Baum, 1998: 98). This has important implications for health workers as Looman and Lindeke indicate in relation to nurses (Looman & Lindeke, 2004).

In summary, health promotion addresses the personal, social, spiritual, economic and environmental determinants of health. Different approaches are used including medical, behavioural and socio-environmental approaches. While medical and behavioural approaches to health promotion focus on risky behaviour and the prevention of disease, a socio-environmental approach addresses the social determinants of health in a holistic way through the strategies of the Ottawa Charter. This is the approach I have used. Social capital is increasingly recognized as important in health promotion. The two concepts "community participation" and "intersectoral collaboration", which were considered essential in the Alma Ata Declaration but were later marginalised when comprehensive primary health care lost the breadth of its vision and became limited to selective primary health care, have found a new home in the health promotion initiative.

2.4 HEALTH PROMOTION IN SOUTH AFRICA

A review of the determinants of health in South Africa, and, in particular, the Western Cape where the research was conducted, highlights reasons for the poor health of a large proportion of the population. South Africa had a population of 46.4 million in 2003 (Western Cape: 4.7 million), with 54% of the population living in urban areas (Western Cape: 88.9%) (Day & Hedberg, 2004: 354). The poverty prevalence (proportion of people/household living in poverty) in 1998 was 40.9% nationally (Western Cape: 7.5%). Goldstein (Goldstein & Usdin, 2004: 318) reports that 22% of households go hungry every day and 71% of all children live in poverty. In 2002 40.9% of people aged 15-64 were unemployed (Western Cape: 25.5%) (Day & Hedberg, 2004: 356). In 2002 life expectancy at birth was 49.9 years for men and 55 years for women (Western Cape: 59.3 years and 66.1 years respectively) (Day & Hedberg, 2004: 357).

Bradshaw and Nannan describe South Africa as having a "quadruple burden of disease" (Bradshaw & Nannan, 2004: 45). These include the impact of HIV/AIDS, the high injury

burden as a result of violence, conditions related to underdevelopment including infectious diseases, and chronic diseases associated with lifestyle.

South African youth[2] form 43% of the total population including 12.5 million children enrolled in schools (MRC, 2002). Youth risk behaviour and experimentation during adolescence is common and may, in the long term, result in health problems. The findings of the 2002 National Youth Risk Behaviour Survey (NYRBS) indicate many learners experience violent behaviour: 14.9% were threatened or injured by someone with a weapon; 13.6% reported assault by a boyfriend/girlfriend; and 9.8% were forced to have sex. Emotional distress was reported by 24.6% of learners who had sad or hopeless feelings that extended for two weeks or more; and 27.8% of those who attempted suicide needed medical treatment. Substance abuse was common and nationally 30.5% of learners reported having smoked cigarettes; 49.1% reported having consumed one drink of alcohol. In 2002, 37% of youth participated in insufficient physical activity, including 43% of females and 30.5% of males.

Sexual behaviour included 41.1% of learners who reported having had sex, with 14.4% having their first sexual encounter aged 14 years or younger. In 2002 the prevalence of teenage pregnancy was 16.4% (Western Cape: 16.4%) and teenage mothers 13.2% (Western Cape 13.7%) (MRC, 2002). The South African Health Review 2003/4 further states that in 2002 HIV prevalence was 11.4% of the total population including 10.2% of the 15-24 year old age group (2003), 5.6% of the 2-14 age group, and 15.7% of health workers (Day & Hedberg, 2004: 362).

Nutritional problems are common. Amongst children aged 1-9 years in 1999, 6% were overweight, 10.3% were underweight and 21.6% had growth stunting (Day & Hedberg, 2004: 367). The prevalence of Foetal Alcohol Syndrome (FAS) on Stellenbosch farms in the Western Cape was 5.7% in children aged 5-8 years with a stunting prevalence of 30.8% (TeWaterNaude et al., 2000).

[2] Youth: Children and adolescents under age 20.

The prevalence of disability, including both children and adults, was estimated at 6.5% in 1996 and 5.0% in 2001 (Western Cape 4.1%) (Day & Hedberg, 2004: 169, 358). The 1999 CASE study indicated an overall prevalence of disability of 5.9% with the following breakdown: seeing disability 1.7%; movement disability 2%; hearing disability 1.0%; emotional disability 1.1%; intellectual disability 1.1%; communication disability 0.8%; and learning disability 1.2% (McLaren, Solarsh, & Saloojee, 2004: 168).

Despite an inequitable socio-economic profile, major changes in policy, based on the Constitution of South Africa (1996), have taken place in South Africa since 1994. In the health sector the move to a primary health care approach and a district health care system has transformed a fragmented health system into a unified, decentralised health system (African National Congress, 1994; Republic of South Africa, 2004). Health care is now to be based on the principles of "equity; access to services; quality; overcoming fragmentation; comprehensive services; effectiveness; efficiency; local accountability; community participation; developmental and intersectoral approach; and sustainability" (Republic of South Africa, 2004: chap. 5 30,2).

The South African health policy advocates a health promotive approach to health care while indicating the provincial health services have the responsibility to: "promote health and healthy lifestyles" (Republic of South Africa, 2004: 16). The Department of Health (1997) recognises that the social, political, economic and physical environment needs to be addressed to make all in South Africa make healthy choices. This is the broad holistic goal of health promotion. The policy supports the WHO principles of "Health for all by the year 2000" including equity; empowerment and respect; participation; and multisectoral activity. Implementation of health promotion is to be based on the five strategies of the Ottawa Charter: healthy public policy will be promoted in all sectors; a healthy environment will be promoted; community action to improve health through empowerment will be facilitated; personal skills development will take place in the formal and informal education sectors; and the health services will be reoriented to

become relevant, appropriate and provided near to where people live (Department of Health, 1997).

The broad aims of health promotion in South Africa have been defined in the draft health promotion policy as:

> … to improve health and well-being of all South Africans through integrated and comprehensive interventions, involving all relevant sectors, that enhance the physical, social, spiritual and emotional well-being of all, and contribute to the prevention of the leading causes of psychological problems, diseases, disabilities and death. (Department of Health, 2003a: 14)

Many successful health promotion programmes, based on the five key areas for action in the Ottawa Charter, have been implemented in South Africa. Prior to 1990 many apartheid resistance activities were aimed at improving health, but not identified as health promotion activities (Coulson, Goldstein, & Ntuli, 1998). This is acknowledged by government: "The struggle for health and development as promoted by the progressive school and progressive practitioners … laid a unique foundation for health promotion based on community consultation, participation and control" (Department of Health, 1997: chap. 18).

Since 1994 important health promotion activities have been implemented. In the Western Cape there have been health promotion activities related to the abuse of alcohol (Brady & Rendall-Mkosi, 2005). These have led to farmers changing their practice of the "dop" system, where alcohol is given to farm workers as payment. In the rural areas several NGOs have joined in action including the Dopstop Association, the Farm Workers Association and the Women on Farms Project. There has been skills development and the empowerment of workers; assistance for women who experience domestic violence; activities in partnership with the farmers. Other organisations such as Soul City have used the media effectively to promote health. Multisectoral collaboration and community involvement have increasingly been recognised as essential for successful programmes. The development of health promoting schools is one strategy that is being used in the

promotion of health of all involved in the school community. This is discussed in detail in Section 2.5.

In summary, the inequities in South Africa, in addition to other determinants of health, have led to problems affecting physical, mental, social and spiritual aspects of health of all involved in the school community – learners, their families, teachers and others involved in the school. Some health promotion policies and programmes, including health promoting schools, are being developed and implemented using the principles of the Ottawa Charter.

2.5 HEALTH PROMOTING SCHOOLS

Health promoting schools have been developed internationally and in South Africa. It is the framework that, I will argue in Section 9.2, could be used by therapists to give appropriate support to learners.

2.5.1 Health promoting schools: international overview

As discussed in Section 2.3.3 the school is recognised as an important setting for health promotion. I include a brief overview of the World Health Organisation's support of the development of health promoting schools. In 1993 WHO defined the school as a health promoting setting:

> The health promoting school aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment. (WHO Regional Office for Europe, Commission of the European Communities & Council of Europe, 1993: 1)

The World Health Organisation continued to actively promote the development of health promoting schools through the Global School Health Initiative which was launched in 1995 (WHO, 1998d). The goal of this initiative was to increase the number of schools that can effectively be called "Health Promoting Schools". "A Health-Promoting School can be characterized as a school constantly strengthening its capacity as a healthy setting

for living, learning and working" (WHO, 1998c: 2). In describing the school as an effective setting for the promotion of health, WHO stated: "The school is an extraordinary setting through which to improve the health of students, school personnel, families and members of the community. It is a means to support the basic human rights of both education and health" (WHO, 1995a: 1).

Networks of health promoting schools have been set up in different regions of the world. In 1992 the European Network of Health Promoting Schools (ENHPS) was founded by the World Health Organisation European Office (WHO/EURO), the Council of Europe (CE), and the Commission of the European Communities (CEC) (WHO Regional Office for Europe et al., 1993). Regional Networks developed in the Western Pacific in 1995, and in Latin America and in Southern Africa in 1996. Subsequently, there was a development of health promoting schools in South East Asia and the northern countries of the Western Pacific (WHO, 1996, 1998c, 1998d).

The health promotion focus on a school setting requires the holistic approach put forward in the Ottawa Charter. A health promoting school needs to address: developing healthy public policy, for example developing dietary guidelines; creating a supportive environment, for example providing facilities to dispose of food and packaging; developing personal skills, for example teaching skills related to purchasing a balanced food supply on a finite budget; strengthening community action, for example making links with the community to assist students with food cultivation; and reorienting health services, for example including a dietician or school nurse to work with teachers, parents and students (St Leger, 1997). The focus of health promoting schools is to be on "creating" health as well as "preventing" health problems (WHO, 1998c, 1998d).

In 1995 the WHO Expert Committee on Comprehensive School Health Education and Promotion outlined the challenge faced by schools.

> In virtually every nation schools could do more than perhaps any other single institution to improve the well-being and competence of children and adolescents. Yet evidence suggests that schools around the world have difficulty in addressing

> the critical physical, mental, and social health needs of children and adolescents. (WHO, 1995b: 161)

The WHO Expert Committee emphasized the close association between health and education recognising

> … an investment in education is an investment in health; that the health of children significantly affects their ability to learn; and that schools can be health-promoting environments only to the extent that they are "healthy organisations" for students and staff alike. (WHO, 1995b: 161)

The Committee called on all people

> … to imagine … a world where schools take on this challenge and implement new and exciting ways to coordinate the educational process, the environmental conditions within and outside the school, and the range of available health services to enhance the educational achievement and health of young people. (WHO, 1995b: 165)

The recognition of an association between health and education preceded the developments that have taken place in health promotion since the 1970s. Literature related to health education is reviewed in the following section to clarify the difference between health education and the development of health promoting schools.

2.5.2 Evidence of effective health promoting schools

The close association between health and education has been acknowledged by both sectors. Education is associated with improved health outcomes. For example, a 10% increase in female literacy is associated with a 10% reduction in child mortality (World Bank, 1993). From the late nineteenth century governments began to recognise the health sector had a role to play in education leading to the development of school health services. In 1906 in Britain, for example, the government's recognition of the poor health of recruits for the Boer War and concern that child malnutrition and disease were affecting their education, led to the introduction of school health services (Jamison et al., 1998).

Health Education, which forms one component of health promotion, has become an accepted part of the school curriculum for developing personal life skills in many countries (Lewis, 1993; Massey, 1990). Historically, health education has had the support of WHO (Tones & Tilford, 2001). In 1951 the WHO Expert Committee on School Health Services was formed. It emphasised the importance of developing appropriate health education and teacher training programmes. Throughout the 1970's and 1980's WHO produced reports related to the health of children and youth that support the need for school health education.

Green and Kreuter (1991), however, point out that the goals of educators and health workers may not be the same and they may even have competing priorities. The goal for health workers is "health", which is frequently associated with being free of disease. Usually this goal relates to a health outcome which involves changing behaviour to reduce the disease risk profile of the learners. However, in schools it is the teachers, not health workers, who have the responsibility for providing health education. Unlike health workers, a teacher's priority is an education outcome, related to learners gaining knowledge and developing skills, rather than changing behaviour. Green and Kreuter suggest that school health personnel involved with health promotion need to be sensitive to these differences particularly if they play a role in designing or presenting the curriculum. They comment on how many educators simply feel overwhelmed with the need to get learners to pass exams and resist prioritising broader health goals beyond health education.

There has also been recognition of the limited impact health education has on learners. In 1991 WHO/UNESCO/UNICEF produced the Comprehensive School Health Education: Suggested Guidelines for Action (CSHE). The Guidelines highlight the interplay between health and education: "Efforts to improve school performance that ignore health are ill-conceived, as are health improvement efforts that ignore education" (WHO/UNESCO/UNICEF, 1992: 9). They support a comprehensive approach to school-based health education that addresses factors affecting health in the broader environment, including collaboration between young people, schools, communities and governments.

They recognise the importance of political will and appropriate national education and health policies in addition to the role of advocacy in achieving this. This comprehensive approach to health education includes the principles of health promotion. However, in spite of these guidelines, according to Tones and Tilford (2001) the focus of health education has not always been broad. In Britain, for example, the focus has remained on the individual with evaluation of a successful outcome measured by changes in the learner, the teacher or the family's behaviour. Lewis (1993), however, suggests that comprehensive school health education in Britain has to some extent embraced broader health promotion strategies including the development of policy, the use of advocacy and partnership with the community. It is a shift that started in the 1980's and 1990's away from a focus on disease prevention (Lewis, 1993). In his opinion the difference between the old health education and the health promoting school "… lies in the strategies devised for achieving change and in the explicit whole-school planning and commitment to the ideal" (Lewis, 1993: 166).

Two systematic literature reviews of health promotion in schools and health promoting schools indicate that a multifaceted approach, consistent with the health promoting schools approach, is more likely to have positive outcomes (Lister-Sharp, Chapman, Stewart-Brown, & Sowden, 1999). The reviews indicate that most health promotion interventions are able to increase the learners' knowledge but that changing other factors that influence health, including attitude and behaviour, is harder to achieve. This needs the broader health promoting schools approach that includes environmental change, changes in the school ethos, and involvement of the family and community.

However, further research is needed to provide evidence on the effect of health promoting schools. Tones and Tilford comment: "To date there is a relatively small number of studies to support strong conclusions on the whole health promoting school approach to health promotion, although there is an increasing amount of positive comment on developments" (Tones & Tilford, 2001: 244). In their opinion, for health promoting schools to be effective teachers need to have a good understanding of the holistic nature of health promoting schools starting from their initial training and for this

to continue through in-service training. Health promotion strives to reduce health inequalities and this needs the ability of teachers to identify the social determinants of health. Additionally, Tones and Tilford emphasise the importance of developing strong links with the community through the development of health promoting schools to reach children who for a variety of reasons are excluded from education. Without this collaboration with the community Baum indicates there is the possibility of the school becoming isolated and unable to identify either the social and political determinants, which "would encourage victim blaming of institutions" (Baum, 1998: 457), or the resources available in the community.

In summary, health promoting schools have the potential to make a significant impact on the health and education of children and youth. The scope of school health education, including comprehensive health education, is more limited than the development of health promoting schools that focus on whole-school development and address policy and environmental issues (Baum, 1998). Health education forms only one component of health promotion. The development of health promoting schools in South Africa is reviewed in the next section.

2.5.3 Health promoting schools in South Africa

Health promoting schools have been developed in South Africa in an attempt to address historical imbalances and injustices, to improve the health of learners, and to facilitate learning. In a 1996 study many schools in South Africa were found to be in very poor condition: 20% of learners were in schools without water within walking distance; 45% of learners were in schools without electricity; and 55% of learners were in schools without toilet facilities (School Register of Needs Survey 1996 as cited in Swart & Reddy, 1999). The School Register of Needs Survey done in 2000 (as cited in Chisholm, 2005) indicated some improvement in basic facilities, but an increase in the number of schools reporting weak or very weak buildings. In 2004 Chisholm indicated that the quality of schools in the informal settlements in urban and rural areas remained poor (Chisholm, 2004). Improvements have taken place, for example, in 1996 55% of learners were without toilet facilities and only 16.6% without toilet facilities in 2000. However, at

the time of the survey, 15% of the toilets, mainly in rural areas, were not working and 35% of schools reported criminal incidents in the school (Department of Education, 2000). This school environment inevitably has a negative impact on the learners' physical, mental, emotional and social well-being (Department of Health, 2000). The grossly inequitable provision of the health services under apartheid has continued to have an impact on the health of learners.

School health services in South Africa have until recently used a limited medical model that included screening for visual and auditory impairments, growth monitoring, assessment of nutrition, and health education (Swart & Reddy, 1999). Health promotion strategies of the Ottawa Charter have been largely ignored. The new school health policy of 2003 is based on a primary health care approach with objectives that focus on health promotion:

> To support educators and the entire school community by creating health promoting schools; to address barriers to learning; to act as a safety net for children who did not have access to services in their pre-school years; and to provide appropriate health education and health promotion within schools. (Department of Health, 2003b: ix)

The development of health promoting schools in South Africa started in 1994 with a workshop attended by the state education, health and welfare sectors, the Medical Research Council, the University of the Western Cape and the University of Cape Town (MRC, UWC, & WHO, 1994). This development was supported by the Centres for Disease Control (CDC) (Kolbe, 1999) and consultation with the World Health Organisation and UNICEF took place (Department of Health, 2000). The initial workshop was followed by the first national Health Promoting School Conference in South Africa in January 1996 that identified the goals of health promotion in schools as being to:

- develop settings and structures that promote and sustain health (healthy policies);
- improve the physical environments within which children live, work and play (healthy environments);

- improve children's capacity to become and stay healthy (health education);
- reduce the number of children who are affected by learning difficulties (early detection of learning difficulties);
- reduce the number of children who are at risk of illness, injury or premature mortality (early detection of disease and risk reduction);
- improve the health and quality of life of children who experience learning difficulties, disease, injury or disability (remediation, treatment and on-going care). (Health Promoting Schools Conference, 1996)

The conference identified intersectoral action, in particular between health and education, as crucial to building effective schools and highlighted the need for appropriate capacity development to enable people, including the education support services, to work in intersectoral teams. The conference criticised the support generally available for schools, highlighting: "… the gross inadequacy and inequality of health and education support services in South Africa" (Health Promoting Schools Conference, 1996: 9). It recommended that support services move away from a "curative, problem-oriented approach" to a "preventative and health promotive" framework using an integrated approach to curative, preventive and health promotive services (Health Promoting Schools Conference, 1996: 9). This need for a change in the role of the education support services, and in particular the therapists, is discussed in greater depth in Section 3.2.2.

At this national health promoting schools conference, Shisana, South Africa's then Director-General of Health, referred to WHO's list of advantages of a health promoting school:

- It utilises a holistic model of health.
- It involves families by encouraging their participation in the development of health skills and knowledge of their children.
- It addresses the significance of the physical environment in contributing to the health of children.
- It recognises the importance of the social ethos of the school in supporting a positive learning environment.
- It focuses on active student participation in the formal curriculum to develop a range of life-long health-related skills and knowledge.
- It enhances equity in education and health raising the competencies of girls and women in the community.

- It provides a positive and supportive working environment for school staff.
- It enables school and the local community to collaborate in health initiatives, which benefit school students, their families and community members. (Shisana, 1996)

In 1997 the Report by the National Commission on Special Needs in Education and Training (NCSNET) and the National Committee on Education Support Services (NCESS) highlighted the role of health promoting schools in developing an environment that is safe and supportive for learners and others in the school (Department of Education, 1997). The Report made the recommendation that all schools become health promoting schools:

> All aspects of the "health promoting school" strategy should be adopted at all centres of learning to ensure the development of health promoting policy, a safe and supportive learning environment, strong community links, personal skills development, and appropriate support services. (Department of Education, 1997: 73)

In 2000, following extensive consultation, the national Department of Health in collaboration with the Departments of Education and Welfare, formulated draft "National Guidelines for the Development of Health Promoting Schools/Sites in South Africa" (Department of Health, 2000). The document highlights the opportunity that the development of health promoting schools provides for intersectoral collaboration and for strengthening links between the school and the community. The Guidelines highlight that, as a result of problems in the social and school environment in South Africa, many learners, teachers and parents are not healthy and have had few opportunities for personal development.

The Guidelines make the important link between health promoting and inclusive schools and emphasise the need for appropriate education support services. The development of inclusive schools, that address barriers to learning, could be developed within this health promoting schools framework: "The inclusive school perspective could also be located

within this framework, with the principle of inclusion being one key value, principle, and strategy for promoting well-being" (Department of Health, 2000: 20).

The Guidelines emphasise the relationship between values and health:

> This includes the values of promoting *well-being* through empowerment of all members of the school community, and a commitment to the development of a supportive, welcoming and *inclusive* ethos which respects diversity and addresses all forms of discrimination. (Department of Health, 2000: 21)

The Guidelines support the health promotion values in the Ottawa Charter and successive World Health Organisation documents. These include equity through redressing injustice and resource imbalances, respect for diversity and human dignity, and community empowerment. They recommend the use of the health promoting schools framework "for addressing the many challenges facing the country at present, and for promoting optimal well-being and development of all members of the teaching and learning community" (Department of Health, 2000: 11).

The Guidelines emphasise that using the health promoting schools framework highlights the importance of education support services and the need schools have for this support as they try to meet the challenge of addressing the barriers to learning. "This perspective provides comprehensive strategies for addressing barriers to learning and development, and in particular, for addressing issues that place learners at risk." (Department of Health, 2000: 11). A health promoting schools framework requires holistic support: "Support services have a very important role to play in helping to build a positive teaching and learning environment and responsive curriculum, to minimise and possibly remove barriers to learning and development" (Department of Health, 2000: 11). However, implementation, using a health promoting schools framework, will require a re-orientation of the approach used by the support services: "a major shift from a curative, problem-orientated approach to one which is more preventative, health promotive and developmental" (Department of Health, 2000: 11). This shift will enable the support services to work together in a multidisciplinary and intersectoral way.

> The re-orientation of these support services includes a major emphasis on intersectoral collaboration of support service personnel. The health promoting schools/sites perspective provides practical foci and strategies for bringing together the different sectors, thereby providing a more holistic and coordinated support to schools. (Department of Health, 2000: 11)

This is discussed in greater detail in Section 3.1.5. The following section describes the development of health promoting schools in the Western Cape where my research was undertaken.

2.5.4 Health promoting schools in the Western Cape

Some of the most active growth and development of health promoting schools in South Africa has taken place in the Western Cape Province. In October 1995 the restructuring of the Western Cape Provincial School Health Services gave birth to the formation of the "Reference Group for the Development of Health Promoting Schools" (Cloete, 1997). The Reference Group had representatives from the Departments of Health, Education, and Welfare, NGO's, community-based organisations and volunteers. It had the ambitious goal: "To convert all schools in the Western Cape to Health Promoting institutions" (Cloete, 1997). The strategies to achieve this goal included establishing school-based teams which would consist of teachers, parents, community members, and pupils. These teams would be empowered to plan, implement, monitor and evaluate health programmes, in collaboration with health personnel. Health promotion programmes, based on the five principles of the health promoting school (healthy policy, creating a supportive environment, developing personal skills, strengthening community action, and reorienting education support services) would be implemented at the schools.

As argued in Section 2.5.2, an effective relationship between health and education is mutually beneficial. An increase in the level of education leads to improved health outcomes, and improved health facilitates learning. A multisectoral approach, involving both health and education sectors, is essential for the development of health promoting schools to succeed. However in South Africa, coordination between the two sectors has been difficult with health and education districts having different geographical

boundaries (Swart & Reddy, 1999). In addition there is some debate as to which sector needs to lead this process. At the National Health Promoting School Workshop in Cape Town in November 1997 Adams, a school nurse actively involved in health promoting schools in the Western Cape, suggested the health sector needed to take the lead role in initiating the process, but that the education sector take it further in terms of the implementation of the process and the development into a health promoting school:

> The role of School Health Services and the school nurse in particular, should be recognised as an integral part of the initiation and development of health promoting schools. The role of the medical officer and school nurse would be to act as initiators and facilitators of the process while the principal and staff take the process further. (Adams, 1997)

Swart and Reddy (1999), likewise, point out that, in the Western Cape, the health sector has been most active in initiating the development of health promoting schools. They suggest that, for this process to be sustained, the education department, particularly individual schools, needed to accept the leadership, with ongoing support from health.

In summary, there has been a development of health promoting schools internationally and in South Africa, including the Western Cape. This development highlights the close relationship between health and education and the need for multisectoral cooperation to promote health. The development of health promoting schools has been identified as an appropriate framework within which inclusive schools could develop given appropriate, holistic support as described in the Guidelines for the development of health promoting schools in South Africa (Department of Health, 2000).

2.6 SUMMARY

In this chapter I have reviewed the literature on health, the primary health care approach and the emergence of health promotion internationally and in South Africa. I have reflected on how the emergence of a comprehensive health promotion approach was a response to the undermining of the comprehensive primary health care approach, highlighting the dangers of a selective approach. I have reviewed the development of health promoting schools internationally and in South Africa, and in particular the

Western Cape Province. I reviewed the literature on the association between health promoting and inclusive schools and the importance of a comprehensive health promotive approach to support for schools. In Chapter Three I review the literature on inclusive education and education support services, with a focus on the support provided by therapists.

CHAPTER THREE

LITERATURE REVIEW: AN INCLUSIVE EDUCATION FRAMEWORK

This chapter reviews the literature on inclusive education providing the background to the role of therapists in the provision of support in schools. The aim of this research was to develop an appropriate and integrated approach for therapists to support schools within an inclusive and health promoting schools framework in South Africa. The shift to inclusive education internationally and in South Africa is described. The chapter focuses on implications for the therapists and the competencies they need for effective support.

3.1 INCLUSIVE EDUCATION

While political and social changes brought about new developments in the health sector after World War 2, parallel developments also took place in the education sector with the move to inclusive education. Inclusive education has been defined as a policy based on inclusion of all, regardless of differences, in a single education system (Donald, Lazarus, & Lolwana, 2002). Concern for human rights and the need for an equitable society were at the heart of this development (Engelbrecht & Green, 2001).

3.1.1 Inclusive education: international overview

Education is considered as a basic human right. The Universal Declaration of Human Rights (United Nations, 1948: Article 26) includes the right of everyone to education.

> Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedom. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups…

From the 1960s, with the development of the disabled peoples' movement, the United Nations included a focus on the rights of children with disabilities, including their right to

education (Forlin & Forlin, 1998). The United Nations' Convention on the Rights of the Child (United Nations, 1989: Article 23, 1) emphasises the importance for a child with a disability to be given the opportunity for a life of dignity that promotes self-reliance and being actively included in the community. The United Nations' Standard Rules on the Equalisation of Opportunity for Persons with Disabilities recognizes the right of people with disabilities to education at primary, secondary and tertiary level, specifically stating that this should be an integrated part of the education system (United Nations, 1993a: Rule 6).

Despite the right to education articulated by the United Nations, in the 1990s, throughout the world, large numbers of children, including many children with disabilities were still out of school. Ahuja (2000) cites UNESCO's 1998 report: "Worldwide an estimated 113 million primary school age children are not attending school and 90% of them live in low and lower middle income countries. Over 80 million of these children alone live in Africa."

Vayrynen, (2000), of UNESCO, emphasises that education policies developed for learners with special educational needs must include all learners who are at risk of being excluded from education, not only learners with disabilities. This includes learners who may drop out as a result of poverty, hunger, malnutrition, environmental factors, cultural reasons, or impairments that impede their progress. It includes learners who repeat classes, who develop more slowly than their age-peers, street and working children, learners with HIV/AIDS, juvenile offenders and children of incarcerated parents, refugee populations, ethnic/linguistic minority groups, and children from remote areas. Inclusive education is not about how a small group of learners could be attached to ordinary schools but it lays the foundation for the transformation of the education system.

Inclusive education has been defined by the Enabling Education Network (EENET) in Britain as acknowledging that all children can learn; acknowledging and respecting differences in children including age, gender, ethnicity, language, disability, HIV and TB status; enabling education structures, systems and methodologies to meet the needs of all

children. It is viewed as a part of a wider strategy to promote an inclusive society; a dynamic process which is constantly evolving; and it need not be restricted by large class sizes or a shortage of material resources (Miles, 2000).

In 1990, in an attempt to address the need for education, the World Conference on Education for All: Meeting Basic Learning Needs adopted the slogan "Education for all by the year 2000" (UNESCO, 2000). Subsequently, in 1994, more than 300 participants representing 92 governments and 25 international organisations met in Salamanca, Spain, for the "World Conference on Special Needs Education: Access and Quality". The Salamanca Statement, produced at the conference, identifies the need for inclusive education, indicating that it requires fundamental policy shifts, and recommends that all education is provided in ordinary schools. The document recognizes:

> … the necessity and urgency of providing education for children, youth and adults with special educational needs within the regular education system … (Section 1)
> … Regular schools with this inclusive orientation are the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all. Moreover, they provide an effective education to the majority of children and improve the efficiency and ultimately the cost-effectiveness of the entire education system.
> (UNESCO, 1994: Section 2)

In 1999 UNESCO proposed the integration and transformation of the two independent movements in education internationally, Education for All and Special Needs Education, to encourage communities, schools and education systems "to reach out and respond to the full diversity of learners; to all those who experience barriers to learning and participation in education" (UNESCO, 1999: 29). Since that time there has been increasing support for inclusive education, on both educational and social grounds, from the United Nations, UNESCO, UNICEF, and the World Bank (Vayrynen, 2000). Although support has come from many sectors in society, parents of children with disabilities and organisations of people with disabilities have frequently been the most vocal advocates (Engelbrecht & Green, 2001; Reiser, 2000). "Inclusive schooling is a continuing movement against educational and ultimately social exclusion" (Slee, 2000).

In the USA legislative change for inclusion began with the 1975 Education of All Handicapped Children Act (Public Law 94-142), mandating the opportunity for free, appropriate education for all children (McLaurin, 1984; Mitchell & Lindsey, 1979). Subsequent legislative changes included the Individuals with Disabilities Education Act which mandates related services, including therapy (Swinth & Hanft, 2002). In Britain the 1978 Warnock Report, followed by the 1981 Education Act, changed the way education was provided. The system of classifying learners according to their specific impairment, with subsequent placement in a school for learners with a particular impairment, was replaced by a single category: "children with special educational needs" (Danks, 1990; Thompson & Lillie, 1995). This Act had a principle that learners with special educational needs should be educated in ordinary schools. In Ireland education policy changes also provided for education for all learners in ordinary schools, wherever practical (Mahon & Cusack, 2002). In France the legislation gave young disabled people the right to be educated in ordinary schools in 1975 (Belmont & Verillon, 1999). Similar changes, with changes in policy to facilitate the inclusion of all learners in ordinary schools, took place in Canada, Australia and New Zealand. Likewise in developing countries there was a move to legislate for inclusive education. For example in Costa Rica the Equal Opportunities Law for Persons with Disabilities was passed in 1996. This involved the restructuring of education to ensure full participation (Stough, 2003). And in Pakistan there was a move away from separate special schools to inclusion (Khan, 1998).

The education sector recognises that inclusive education cannot succeed without the involvement of other sectors. Ahuja (2000) describes inclusive education as a "multisectoral concept". Planning and monitoring of inclusive education needs to include health, welfare and other sectors. This multisectoral collaboration should, for example, be a mechanism for addressing difficulties experienced in the provision of education in rural areas.

> If the countries are to develop the education systems to be more inclusive, multisectoral collaboration becomes crucial. As many reasons for school failure, drop-out, developmental delays, etc. are [other] than educational, co-operation

> and collaboration between and across sectors is needed. Structures or procedures to facilitate multisectoral collaboration need to be developed. (Vayrynen, 2000)

In spite of policy changes, the implementation of inclusive education internationally has been difficult (Vayrynen, 2000). For example, there are reports from New Zealand of learners with special needs remaining marginalised as principals of schools find the education policy too complex (Brown & Wills, 2000). Difficulties with inclusion have been experienced where the organisation of the school, the school culture, and the ethos of the school are not inclusive (Carrington, 1999; Slee, 2000). The curriculum has been identified as leading to exclusion. In addition, where parents' voices are not heard effective inclusion has not taken place (Paige-Smith, 2000).

Despite these difficulties, there is still strong support for inclusive education internationally and the possibilities it presents for the development of a more inclusive society. As Oliver, in his closing remarks at the International Special Education Conference (ISEC) 2000, on the importance of moving from special education to inclusive education stated:

> Special education has no choice; it can begin to change itself from within or be swept away by the tide of history which is washing over us all as we enter the twenty first century. It can be part of the struggle to produce a more inclusive world or it can continue to align itself with the forces of exclusion. The former strategy offers us all the possibility of a decent future; the latter offers a few of us the illusion of a safe and stable world. I hope that special education is mature enough to make the right choice. (Oliver, 2000)

3.1.2 Inclusive education in South Africa

A radical transformation in education policy to an inclusive education system has taken place in South Africa since 1994. The South African education system has a history of division based on race, disability classification and profound inequity. Policy changes have been based on a human rights perspective, in line with the Constitution of South Africa (Republic of South Africa, 1994) which states:

> Every person shall have the right … to basic education and to equal access to educational institutions (Republic of South Africa, 1994: 32, a)
> … No person shall be unfairly discriminated against, directly or indirectly … on one or more of the following grounds in particular: race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture or language. (Republic of South Africa, 1994: 8, 2)

The South African Schools Act (1996), which emphasises inclusion of all learners in ordinary schools including learners identified as having "special educational needs", led to the formation of the National Commission of Special Needs in Education and Training (NCSNET) and the National Committee for Education Support Services (NCESS). They "… were appointed to investigate and make recommendations on all aspects of 'special needs and support services' in education and training in South Africa" (Lazarus, 1997).

The NCSNET/NCESS Report (Department of Education, 1997) proposes a vision of the new education system, and the principles and the strategies to achieve this vision. It is a vision of education for all, developing centres of learning that are inclusive and supportive, so that all learners can participate actively in the education process, while developing and extending their potential to participate as equal members of society. It is based on the principles of human rights and social justice; inclusion in the local community; access to a single inclusive education system; access to the curriculum including appropriate support; equity and redress for learners excluded in the past; being responsive to the needs of community and drawing support from the community; and cost effectiveness while ensuring the system is appropriate and sustainable. The strategies recommended focus on changing the system, not the individual learner – developing a system that is open to being transformed as it accommodates diverse individual learners. At the heart of this is identifying and addressing the factors that lead to "barriers to learning", and whether these are related to the learner, the family, the classroom, the teacher, the community or social factors. This includes:

- multisectoral advocacy campaigns in the community to challenge discriminatory attitudes to diversity.
- the integration of special and ordinary schools into a single integrated system of education;

- support services that move from a focus on individual learners to support for teachers and the system so the teachers can respond to the needs of learners;
- ensuring the environment is free of barriers to access;
- holistic organisational development through whole-school development;
- a flexible curriculum; promotion of the rights and responsibilities of parents, teachers and learners;
- capacity development of teachers, education support personnel, parents and others from the community;
- an integrated support service involving different sectors including government and NGOs;
- drawing on community-based support systems;
- a preventive and developmental approach to the provision of support including the development of health promoting schools;
- a funding strategy ensuring redress, sustainability, while facilitating access to education for all learners.

In 2001 Education White Paper 6 was produced describing the vision of the new inclusive education system: "… at the heart of this White Paper [is] a determination to establish an inclusive education and training system as our response to the call to action to establish a caring and humane society…" (Department of Education, 2001: 20). Education White Paper 6 (Department of Education, 2001: 16) defines inclusive education and training as:

- acknowledging that all children and youth can learn and that all children and youth need support;
- accepting and respecting the fact that all learners are different in some way and have different learning needs which are equally valued and an ordinary part of our human experience;
- enabling education structures, systems and learning methodologies to meet the needs of all learners;
- acknowledging and respecting differences in learners, whether due to age, gender, ethnicity, language, class, disability or HIV status;

- broader than formal schooling and acknowledging that learning also occurs in the home and community, and within formal and informal modes and structures;
- changing attitudes, behaviour, teaching methodologies, curricula and the environment to meet the needs of all learners;
- maximizing the participation of all learners in the culture and the curricula of educational institutions and uncovering and minimizing barriers to learning;
- empowering learners by developing their individual strengths and enabling them to participate critically in the process of learning.

In summary, inclusive education is a system of facilitating access to and participation in education. It is a process of empowering learners. It is about respecting diversity amongst learners and providing opportunities for all learners to learn and participate to their maximum at school, in the home and in the community. It includes the provision of appropriate support to the education system, the curriculum and directly to the learner. It involves changing attitudes and facilitating the removal of barriers to learning (Department of Education, 2003a, 2003b).

3.1.3 Barriers to learning and development

As described above, the recognition of the need to identify and address barriers to learning causing learning breakdown or exclusion from the education system, with a focus on changing the system and not the individual learner, is an important shift that has taken place. In 1999 UNESCO described the identification of barriers to learning for all children as important to the transformation of education (UNESCO, 1999). A United Nations representative has described the South African statement on inclusive education as "the most advanced policy statement on addressing barriers to learning and participation" (Vayrynen, 2000). The NCSNET/NCESS Report states: "the central challenge facing education … [is] recognising and addressing the diverse needs of the entire learner population and minimising, removing or preventing barriers to learning and development" (Department of Education, 1997: i). The Report argues that the term "learners with special education needs" does not describe the factors that may cause exclusion from learning and as a result ignores the significant majority of learners who

experience learning breakdown in South Africa. This was reinforced in Education White Paper 6 (2001) which states:

> The approach advocated in this White Paper is fundamentally different from traditional ones that assume that barriers to learning reside primarily within the learner and accordingly, learner support should take the form of specialist, typically medical intervention. (Department of Education, 2001: 24)

Barriers to learning and development are defined as factors which hinder teaching and learning (Department of Education, 2001, 2003a). They include factors that are related to specific learners (specific learning needs and styles) or teachers (personal factors, teaching approaches, attitudes); aspects of the curriculum (see Section 3.1.4); the physical and psychosocial environment that teaching and learning takes place in (buildings, management approaches); the learner's home environment (family dynamics, cultural and socio-economic background); and the community and the social dynamics.

3.1.4 The curriculum

The curriculum has been identified by the Department of Education (2003a) as a focus area for support. Donald et al. (2002) describe the curriculum as including: content; the structure of the programme; the methods of teaching and learning; language or medium of instruction; methods and processes used in teaching; pace of teaching and time available; the methods of assessment and evaluation; learning materials and equipment; classroom organisation and management; as well as the process of what happens in school.

The Revised National Curriculum Statement (RNCS) was developed in South Africa to address the past inequities in education and promote the values of the Constitution of social justice, equity and democracy (Department of Education, 2002). It is comprised of eight learning areas: Languages, Mathematics, Natural Sciences, Technology, Social Sciences, Arts and Culture, Life Orientation, and Economic and Management Sciences. Life Orientation, for example, is intended to equip learners for life in society. It includes:

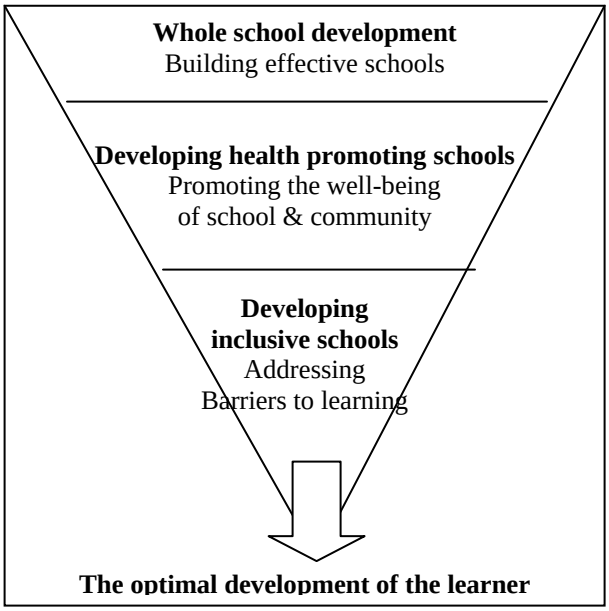
health promotion; social development; personal development; physical development and movement; and orientation to the world of work.

3.1.5 Health promoting schools and inclusive education: within a whole school development framework

The Department of Health's (Department of Health, 2000) Draft national guidelines for the development of health promoting schools/sites in South Africa, discussed in Section 2.5.3, highlight the need to use a whole school development approach. Whole school development is a broad framework for building effective schools. It is described by Donald et al. (2002) as a general term including school effectiveness, school improvement, and school organisation development. The Guidelines describe the purpose of whole school development as: to promote development in all areas of school learning, promoting effective teaching and learning.

The Department of Health (2000), Donald et al. (2002), Engelbrecht and Green (2001), and Lazarus, Davidoff, and Daniels (2000) argue for health promoting schools development to be a strategy for whole-school development. The health promoting school approach would serve as a "lens" through which development of the school can be viewed. They further argue for the development of an inclusive school to be located within this health promoting schools framework, as illustrated in Figure 3.2.

Figure 3.1: Developing health promoting schools within whole school development
(Department of Health, 2000)



Lazarus et al. (2000) argue that the values contained within the acceptance and celebration of diversity, that are at the heart of inclusive education, are key concepts within the health promoting schools framework. Values, unlike beliefs, are evident in behaviour (Tilford, Green, & Tones, 2003). An inclusive and health promoting schools framework implies that inclusion is a key value in the promotion of the well-being of the whole school community. If the culture or ethos of the school is based on values that are committed to inclusion this will be reflected in the behaviour in the school, including policies and practices. There would be a focus on developing a flexible and accessible curriculum and an environment that is welcoming and non-discriminatory. "A health-promoting and inclusive school is one which fosters a *supportive* and *non-discriminatory* school culture" (Donald et al., 2002: 147). The Guidelines (Department of Health, 2000) highlight the importance of values promoting well-being through empowerment of all in the school community and an inclusive ethos where diversity is respected in inclusive and health promoting schools.

Whole-school development is generally based on an ecosystemic theoretical perspective (Donald et al., 2002). In this perspective the individual is understood in relation to other

people or groups of people, the systems and the social environment. This leads to multidimensional relationships all affecting each other and being affected by one another. For example, in school the individual learner has multiple relationships that include: other learners; teachers; the school and classroom environment. But the learner's relationships beyond the school include: the family; the community; and society more broadly. The ecosystemic perspective emphasises that all these relationships actively interact with one another thus affecting people's psychological development, their social environment and the systems in it. It recognizes that what happens in one part of this system has an impact on the rest of the system. The ecosystemic perspective explains why removal of the barriers that learners experience, affecting their learning and development, involves identifying and addressing the underlying social issues.

As with the ecosystemic theoretical perspective, health promotion action includes both a focus on developing personal skills and the development of the individual, and creating supportive environments (WHO, 1986). The ecosystemic view explains the relationship between individuals and their social context as one in which people are active participants in changing their social context, not simply passively affected by this context (Donald et al., 2002). This perspective can also be used to identify the process of change in development and healing (Donald et al., 2002). This links closely to the health promotion strategy of empowerment which was emphasised in the Jakarta Declaration (WHO, 1997). It is within this broad ecosystemic theoretical perspective that whole school development and the strategy of inclusive and health promoting schools reside.

In summary the move to inclusive education in South Africa and internationally is based on concern for human rights. In South Africa there have been changes in the education policy to an inclusive education system to ensure all have access to learning. Barriers to learning and development that may be present at all levels of the system need to be addressed to enable all learners to gain access to the curriculum. Effective schools will be based on whole school development, within the ecosystemic theoretical framework. It is argued that building inclusive and health promoting schools is an important strategy for whole school development.

3.2 EDUCATION SUPPORT SERVICES

Education support services have been identified internationally as essential for effective inclusion. These support services include a wide range of people from different disciplines, from areas within the school, school health, and from the community. People who give support include occupational therapists, physiotherapists, speech and language therapists, community-based rehabilitation workers, learning support teachers, psychologists, nurses, doctors, and social workers (Department of Education, 1997; Donald et al., 2002). In this section I review literature related to education support services, with a particular focus on therapists – internationally and in South Africa.

3.2.1 Education support services: role of therapists internationally

The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities recognise the need for adequate and appropriate support services to ensure equal opportunities for people with disabilities (United Nations, 1993a). The Salamanca Statement (1994) also acknowledges the importance of support services in its Framework for Action: "Provision of support is of paramount importance for the success of inclusive educational policies" (UNESCO, 1994: Section D, 49).

Internationally, legislative changes related to inclusive education have had major implications for therapists, particularly in terms of the model of support provision. It has required a shift from a medical model of support to an educational or social model of support, with therapists being required to support educational rather than medical goals (Connolly & Anderson, 1978; Dunn, 1988; Jirikowic et al., 2001; McLaurin, 1984; Swinth & Hanft, 2002; Thompson & Lillie, 1995). Law et al. (2002) refer to this new model of support by therapists as a holistic or ecological model of education support. It involves the shift from mainly providing direct support for individual learners, who were diagnosed with problems that therapists could treat, to mainly providing indirect support for all learners through the therapists' support for teachers and parents. Although the bulk of the literature related to the shift from direct to indirect support within an educational model comes from the USA (Occupational Therapy, Physiotherapy and Speech and language therapy literature) and Britain (Speech and language therapy literature),

literature from Australia and New Zealand indicates similar changes are taking place in those countries (Danks, 1990; NSWPPA State Council, 1998).

Several models of support that are now used by therapists in the USA, Canada and Britain have been described (Boshoff, 2000; Bundy, 1995; Connolly & Anderson, 1978; Dunn, 1988; G. King et al., 1999; McDougall et al., 1999). Dunn (1988) describes three models of occupational therapy service provision defined by the American Occupational Therapy Association in 1987: firstly direct service provision; secondly monitoring; and thirdly consultation. Physiotherapists and speech and language therapists use similar models (Bundy, 1995; Dunn, 1988, 1990; King, McDougall, Palisano, Gritzan, & Tucker, 1999).

3.2.1.1 Direct service provision

Direct service provision involves the use of specific techniques with an individual learner or small group of learners (Dunn, 1988) either inside or outside the classroom (Bundy, 1995). These techniques may require extensive knowledge and the use of clinical judgement, for example, knowledge of the neuromuscular system and the control of movement to gain motor skills.

This approach is still commonly used internationally in spite of acknowledgement of the need for indirect support. Fifteen years after the change in education legislation in the USA, Bundy described occupational therapists as being most familiar with this model, in spite of its limitations. A survey of speech and language therapists in the USA in 1995 found 54% of their time was spent on direct support and only 1% on screening (Peters-Johnson, 1996).

The “pull-out” model, frequently used in direct service provision, where the learner is taken out of the classroom and “treated” in a separate area, has been criticised for being fragmented, with little carry-over of skills and a considerable social embarrassment for children, particularly adolescents (Harn, Bradshaw, & Ogletree, 1999). Other research indicates that one-on-one physiotherapy in the natural educational setting, for example

the classroom, has a better outcome than withdrawal and treatment in a therapy room (Karnish, Bruder, & Rainforth, 1995).

Direct support may have negative educational effects if learners are withdrawn from the classroom and miss teaching time. Bundy (1995) argues that direct service results in the learner losing time to participate in the regular education curriculum. Consequently it should only be used as a last resort: "The decision to interrupt the student's participation in school (even in non academic activity) should come only when the student needs the skills so badly that the disruption is justified" (Bundy, 1995: 79).

Pollack and Stewart (1998) describe how a shift has taken place with therapy no longer focused on changing and "normalising" the learner but rather on enabling successful learning to take place: "The focus of therapy has also changed from a strong emphasis on the remediation of performance component deficits to one of compensation or adaptation to allow the child to perform more successfully, not more normally, in the school setting" (Pollock & Stewart, 1998: 56).

3.2.1.2 Monitoring

Monitoring involves the therapists teaching the teacher, parent or another person how to perform a particular procedure with a learner and then monitoring how this person is performing the procedure (Bundy, 1995; Harn et al., 1999). This could include "activities of daily living, positioning and handling, reach and grasp, fine motor skill development, or coordination needs" (Dunn, 1988: 719). For monitoring to be effective the therapist needs to be able to identify what the specific educational need of the learner is. In some of the literature the term "consultation" is used for this type of support by the therapist (Harn et al., 1999).

3.2.1.3 Consultation

Consultation is recommended for changing the school environment (the human and non-human environment) or the school system so the learner can succeed at school (Bundy, 1995; Jaffe, 1988; Topping, Gascoigne, & Cook, 1998). The therapist's expertise is used

to "… facilitate the workings of the education system" (Dunn, 1988: 720). Research indicates that consultation can meet the needs of the learner, the teacher, the parent and other professionals, as well as the education system (Bundy, 1995; Dunn, 1988). It has been described by Dunn (1988) as an efficient approach to using the knowledge of occupational therapists, resulting in changes to teaching and learning strategies and a better outcome for the learner which is as effective as direct support. Bundy (1995: 78), argues that "…consultation is extraordinarily powerful … I believe it should be the primary form of service delivery for most students".

There are, however, some therapists who question the application of this model. Law et al. point out that consultancy is a role that fits the health system, where people have traditionally consulted "experts", but not the education system, "…where no such culture of expertise exists…" (Law et al., 2002: 150). This may make it difficult for teachers to work with "consultants" in that it suggests power inequality (Hartas, 2004). There is also the opinion that only the more experienced therapists are able to give effective indirect support, while recently qualified therapists need to "…develop their expertise both in assessing and treating children but also in fully understanding the education service within which they be working" (Law et al., 2002: 161). Sandler (1997) raises the question as to whether teachers receive sufficient training to prepare them for the consultative model and whether they have the time to implement the therapeutic strategies. In addition McCartney (1999) points out that although therapists learn to work in partnership in multidisciplinary teams in the health sector, this model is not familiar to teachers and may be a barrier to collaboration.

Nevertheless, legislative changes internationally encourage indirect support and there have been positive results. In New South Wales, Australia, it is reported that, "… the provision of therapy services had changed to a 'consultancy only' model in the majority of schools across the state" (NSWPPA State Council, 1998). The changes in legislation have led to a move away from the focus on direct therapy.

Speech and language therapy literature refers to “collaborative service delivery models” with support in the classrooms replacing “pull-out programs” (Elksnin & Capilouto, 1994; Greenwell, Heggarty, & Woolard, 1998; Harn et al., 1999). Collaboration implies the ability of the therapist and teacher or parent to work together in an equal partnership, rather than in a hierarchical manner. The results of collaboration have been found to be effective, including the use of collaborative consultation (Dunn, 1990), collaborative goal setting with direct support (King et al., 1999) and a combination of direct support, monitoring and collaborative consultation between therapist, parent and teacher (G. King et al., 1999).

3.2.2 Education support services in South Africa

In South Africa education support services are defined as including “… all human and other resources that provide support to individual learners and to all aspects of the system” (Department of Education, 1997: 2). Occupational therapists, physiotherapists and speech and language therapists form one component of these human resources. The South African Schools Act makes the provision of support services mandatory stating that the government “… must, where reasonably practicable provide education for learners with special educational needs at ordinary public schools and provide relevant educational support services for such learners” (Republic of South Africa, 1996: 10). As White Paper 6 states: “… the key to reducing barriers to learning within all education and training lies in strengthened education support service” (Department of Education, 2001: 28). The NCSNET/NCESS Report (Department of Education, 1997) describes the role of the support services as being to minimise and facilitate the removal of barriers to learning as well to prevent these barriers by developing a supportive environment. The Report emphasises that internationally inclusive education has only succeeded when adequate support has been provided to the learner and the system as a whole.

The support services provided in the past in South Africa were inequitable with only a small number of learners receiving highly specialised support services, while the majority of learners received none. Separate support services were set up for learners from different racial groups. Support services set up for white learners were “… fairly

extensive and included specialized interventions and assistance on a number of levels" (Department of Education, 1997: 22) but services for learners from other racial groups, in particular African learners, were "… generally inadequate in meeting the needs which existed and often relied on insufficient resources and provisioning" (Department of Education, 1997: 22).

There have been criticisms of the model of the support provided in South Africa (Department of Education, 1997, 2001). Traditionally the medical model has dominated the approach used by the support services in South Africa, as it had done internationally. This model has focused on the learner's deficits and not educational needs and abilities (Department of Education, 1997). White Paper 6 (2001) recommends a social model of support which it describes as "… fundamentally different from traditional ones that assume that barriers to learning reside primarily within the learner and accordingly learner support should take the form of specialist, typically medical intervention" (Department of Education, 2001: 24). This supports the NCSNET/NCESS Report (Department of Education, 1997) which describes the fundamental shift that is needed by the support services "… away from supporting individual learners to supporting educators and the system so they can recognize and respond appropriately to the needs of all learners and thereby promote effective learning" (Department of Education, 1997: 58). As Lazarus et al. indicate, this involves a focus on preventing barriers to learning and development as well as to providing support to the education system:

> The re-orientation of support services … refers to a major shift from a curative, problem-oriented approach to one, which is more preventative, health promotive and developmental …. Major emphasis [needs to be] on intersectoral collaboration of support personnel. (Lazarus et al., 2000: 19)

This highlights the need for therapists to shift towards a social model of support where the focus is no longer on the learners' impairments and an attempt to change the learners but on the support needed by the teacher, the broader classroom and school, and the family and community (Department of Education, 1997, 2001).

The Department of Education describes this need for mainly indirect support, with a focus on the education system as a whole and not the individual learner:

> The mode of service delivery would largely be indirect and consultative, with the focus on the system rather than on the learner. Individual direct service delivery by these education support personnel to learners is likely to be the exception rather than the rule, occurring only when other centre-based interventions have not proved effective. Exceptions may be assessment and intervention for learners who require specialized intervention in order to overcome barriers to learning and development, whether these are of a permanent or transitory nature.
> (Department of Education, 1997: 88)

The Department of Education recommends new roles for education support personnel with support for the whole school system, teachers, and parents:

> … in assessment and developing appropriate interventions, developing preventative and promotive programmes (e.g. health promoting strategies) and addressing barriers to learning and development through appropriate interventions where the centre-of-learning based teams have not been able to provide solutions.
> (Department of Education, 1997: 97)

The NCSNET/NCESS Report (Department of Education, 1997) describes how therapists and other education support service personnel will no longer work primarily with the learner but also with parents, teachers and the education system as a whole. They would be involved in supporting the process of organisational change in the schools. It suggests that their activities might include: "teaching, consulting, advising, assessing, evaluating, monitoring, guiding, organising support, supplying services, developing accessible curricula, training and empowering parents and adopting key roles of leadership and co-ordination" (Department of Education, 1997: 97).

Implementing the policy of inclusive education involves the development of education support service teams. The 2003 "Conceptual and operational guidelines for the implementation of inclusive education: District-based support teams" describes how the support services will be organised in each education district through the development of district-based support teams. The core purpose of the district-based support team is to

"foster the development of effective teaching and learning in schools and other education institutions" (Department of Education, 2003a: 23).

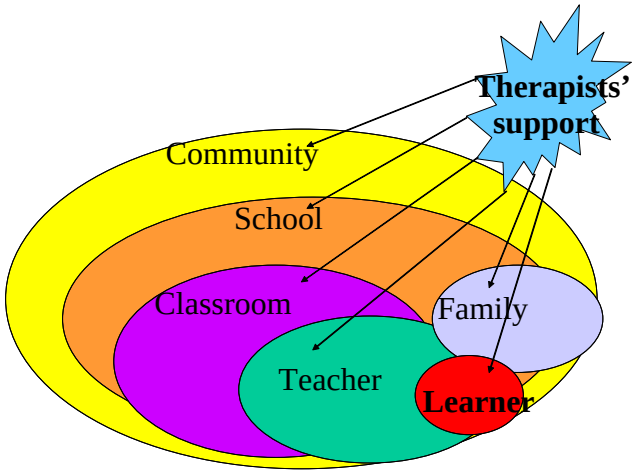
In the Western Cape the district-based support teams, based in each education district, will be co-ordinated by the Education Management and Development Centre (EMDC). EMDCs were developed in the Western Cape Province to facilitate transformation and decentralisation (Langhan, 2000). Their aims include providing quality support to schools and building their capacity.

Teamwork will involve multidisciplinary and multisectoral collaboration. "Collaboration means joint planning, decision making and problem-solving directed toward a common goal" (Stanovich cited in Engelbrecht & Green, 2001: 23). A broad range of professionals, including therapists, will form the team to provide an "integrated professional support service" (Department of Education, 2003a: 7). The support service will be developed to address needs in a holistic way, instead of "the fragmented way in which support is currently provided" (Engelbrecht & Green, 2001: 11).

The primary focus of the district-based team would be support for the institutional-level team at each school (Department of Education, 2003a). This involves building the capacity of the school; identifying learning needs and barriers to learning; identifying the support that is needed; and monitoring and evaluation of this support. The main focus of this support is to provide indirect support to learners with direct support as a secondary focus only if the institution-level support team cannot respond to the need. Therapists, along with other specialist support personnel, would "provide direct interventionist programmes to learners in a range of settings, and/or, serve as 'consultant-mentors' to school management teams, classroom educators and school governing bodies" (Department of Education, 2001: 41). The development of preventive programmes is another task of the district-based support team, including screening and identifying learners or educators who are "at risk". Programmes on social inclusion for example for people with disabilities or HIV/AIDS could also be started. Another focus is linking the schools to the community and local resources (Department of Education, 2003a).

There is little written on the support for schools by therapists in South Africa. An extensive electronic and manual search of the literature did not find local literature describing the support that is provided. Only Struthers and Lewis describe the need for therapists to move from mainly providing direct support to learners to mainly providing indirect support illustrated in Figure 3.2 (Struthers & Lewis, 2004). This research was undertaken to address this obvious gap.

Figure 3.2 Therapists' role in addressing barriers to learning at all levels of the system



In summary, education support services are essential to the development of a successful inclusive education system. Internationally, there has been a shift in the type of support that is advocated, from a medical approach with the focus on problems within the individual to a social or educational approach with the focus on identifying and addressing barriers to learning and development in the system. Internationally three models of support used by therapists have been identified, including direct support, monitoring and consultation. The support to be provided by therapists in South Africa is the focus of this study.

3.3 COMPETENCIES OF THERAPISTS

In this section I present literature on the competencies required by occupational therapists, physiotherapists and speech and language therapists internationally and in South Africa to support the development of an inclusive education system. This is to provide the background for my research question: What competencies do therapists need to support schools in South Africa?

3.3.1 Competencies of therapists internationally

Internationally, therapists working in schools have identified their need for a broader range of competencies than was previously required as a result of the shift from the medical model of support to the educational or social model of support (Harn et al., 1999).

In 1980, following the introduction of the new education policies in the USA, Levangie accused physiotherapists of using "inappropriate and outmoded systems for providing service" (Levangie, 1980: 774). The physiotherapists were criticized for continuing with a medical model of support and not being a supportive part of the educational process. In addition they were criticised for giving low priority to providing support for and sharing knowledge with teachers, parents, other professionals and the community. Levangie suggested that physiotherapists were afraid of losing their professional identity, and identified a lack of professional and legislative guidelines defining their responsibilities as a problem. Following this, professional associations and government agencies produced guidelines and policies related to the implementation of Public Law 94 – 142, including the "Guidelines for physical therapy practice in educational environments" by the American Physical Therapy Association and "Guidelines for occupational therapy services in school systems" by the American Occupational Therapy Association (McLaurin, 1984).

However, implementation of the guidelines and, in particular, the emphasis on the provision of indirect support has been difficult. One reason for this is that therapists do not have the necessary competencies. Training of therapists is criticised for not equipping

them with the broad, holistic range of competencies required for indirect support (Royeen, 1986). It is suggested that one of the reasons for this is that, in the workplace, written job descriptions, or roles of therapists, reflect the language of the medical rather than the educational or social model. For example, it would be better to state the therapist's role is "to facilitate the educational outcomes required", rather than stating "to improve gross and fine motor skills". All roles need to be described within the education context. However, many of these competencies, including knowledge of the social or education model, have not been developed by therapists during their basic training, making it difficult for them to work within the educational model (Connolly & Anderson, 1978).

Providing education support requires some competencies that are specific to occupational therapy, physiotherapy or speech and language therapy while other competencies are generic, appropriate for therapists from more than one discipline. The competencies required by therapists working in schools that are described in literature include specific knowledge, skills and attitudes. In Sections 3.3.1.1 – 3.3.1.3 I have highlighted and italicised the competencies that are required.

3.3.1.1 Knowledge of school culture and curriculum

Apart from discipline specific knowledge, therapists need general knowledge related to working in an educational setting. Jirikowic et al. (2001) identify the need for therapists to be knowledgeable about the school system and to have an understanding of ***school culture***. Therapists need knowledge of the relevant ***education legislation and the associated guidelines*** (Coutinho & Hunter, 1988; McEwen & Shelden, 1995; Mitchell & Lindsey, 1979). Knowledge about the ***curriculum*** is also recognized as essential (Santos, 2002). Harn et al. (1999) explain that it is important to understand the demands of the curriculum on the learner's language and communication skills.

3.3.1.2 Skills

Literature from the USA shows a shift in the skills that are needed since the education policy changed. In the 1980's the approach was still based on a medical model with the

need for the learner to change or adapt. McLaurin, for example, describes the need for specific techniques such as “development and reflex testing, posture and gait evaluation, joint range of motion and muscle strength assessment” (McLaurin, 1984: 674). While these skills may still be needed, in more recent literature, presented below, emphasis is on identifying barriers to learning and support for facilitating learning.

Giangreco recommends that therapists use two criteria to identify if their support is required: Firstly that the support is “educationally relevant” and secondly that it is “necessary” (Giangreco, 1995: 59). There is emphasis on identifying the discrepancies between the learners’ educational performance and the expectations of the teachers or others. Therapists need the ability to ***assess*** individual learners in order to ***set goals*** for interventions that are clearly related to educational outcomes. They need to able to ***evaluate*** and ***record*** the outcomes and describe them to others (Bundy, 1995; Clark & Miller, 1996; Royeen, 1988).

King et al. (1999) recommend therapists have the skills to ***set functional goals*** that take the environmental context into account as this results in improved functioning in school, including improved articulation, productivity and mobility in the school environment.

Therapists need skills to be able to undertake ***preventive activities***. This needs to include ***identifying at risk learners***. Prelock (2000) reports on a successful ***language intervention*** for at risk learners from disadvantaged homes with language delay, and learners with second language learning needs. This involved the speech-language pathologist collaborating with the teacher. ***Screening*** can also be an important preventive activity. Where appropriate, therapists need to be able to screen learners for particular problems (Hall, Robertson, & Turner, 1992; Levangie, 1980).

Indirect support requires different skills. Therapists need skills ***to work with the teachers***, to work in the classroom, and with the broader education system (Harn et al., 1999; Paradice & Adewusi, 2002). This includes the ability to ***modify the curriculum*** (Hirst &

Britton, 1998). Therapists need the ability to ***manage their time*** to meet teachers and others they are collaborating with (Harn et al., 1999).

Therapists' ability to ***collaborate*** with teachers is referred to extensively (Greenwell et al., 1998; Santos, 2002; Topping et al., 1998; Wright & Kersner, 1998). Bundy (1995) describes the relationship between the therapist and the teacher when using monitoring/supervising as very different from that during consultation. In monitoring the relationship is hierarchical, where the therapist ensures that the intervention is done properly without risk to the student. Monitoring requires the therapist to have ***teaching skills***; the ability to ***assess*** the implementer's ability to learn the procedure; the ability to ***listen*** to the implementer's concerns; and the ability to provide skilful ***supervision*** including ***evaluation***. Others refer to the ability to develop a ***partnership*** with parents and teachers (Bundy, 1995; Connolly & Anderson, 1978). Therapists need to have ***consultation skills*** to develop a partnership with parents and teachers (Paradice & Adewusi, 2002).

Therapists need a range of ***teaching skills*** to be able to teach parents (Jirikowic et al., 2001), teachers (Sellers, 1980), assistants, other professionals (Greenwell et al., 1998), key workers (Hirst & Britton, 1998) and culturally and linguistically diverse learners (Harn et al., 1999). This includes teaching them about special positioning for seating, lying or standing; special seating; the use of assistive devices such as orthoses and wheelchairs; lifting and handling techniques; exercises; relaxation techniques (Sellers, 1980); and feeding techniques (Bundy, 1995). They need to be able to motivate the parents or teachers to use the particular strategies by appropriate explanation of their benefits. Therapists need the ability to ***explain their role*** to parents, teachers and the community. They need to be able to use ***appropriate terminology***, and not only medical terms, in all their explanations.

The need for skills to facilitate ***multidisciplinary and multisectoral collaboration*** (as described in Section 3.2.3) is highlighted in the international literature (Belmont & Verillon, 1999; Connolly & Anderson, 1978; McLaurin, 1984). Giangreco (1995)

criticises therapists for working in isolation, using a "unidisciplinary" approach, and not as a team that is focused on educational goals. This leads to ambiguous roles and expectations, and a fragmented support programme. Giangreco emphasises the importance of ***joint decision making*** and the need for therapists to assess, plan, make decisions and implement them as a ***team***. They also need skills to ***resolve conflicts*** that can arise in the team.

Concern has been expressed about the overlap of the roles of the therapists. This can lead to duplication, inefficiency and confusion among themselves and others whom they work with (Campbell, 1997b; Fairbairn & Davidson, 1993). In 1980 Sellers asked physiotherapists in the USA the question: "Have some physical therapists become so egotistical that they regard themselves as being the only professionals trained in dealing with disabled children?" (Sellers, 1980: 1159). Therapists require skills to move beyond the perspective of their particular discipline and its values; to avoid overlaps and gaps in the support service; and prevent recommendations from being made that are contradictory.

Another important skill related to multisectoral and multidisciplinary collaboration is the ability to ***network***. Therapists need to communicate and work with parents, siblings, teachers, respite workers, extended families, educational assistants, community organisations, and school governing bodies. It is suggested that therapists can play a key role in networking:

> [Parents and teachers] believe that therapists have a role to play in fostering partnerships and facilitating that collaboration. They believe that through our holistic approach to our clients we can bring together the child, the family, the school and the broader community to work together in the best interests of all concerned. (Pollock & Stewart, 1998: 67)

Effective ***communication*** is another important skill needed for multisectoral and multidisciplinary collaboration as it has an impact on interpersonal relations (Coutinho & Hunter, 1988). Communication skills identified in the literature include listening skills;

writing and interpreting educational objectives (Levangie, 1980); and resolving verbal challenges effectively (Coutinho & Hunter, 1988).

Therapists need skills to make appropriate ***changes to the environment*** (Griswold, 1993; Law & Dunn, 1993; Pollock & Stewart, 1998). This includes identifying architectural barriers; ensuring safe and accessible buildings and transportation (McLaurin, 1984: 675); making changes to classroom materials to facilitate participation in a way that is appropriate for the style, values and purpose of the particular teacher (Bundy, 1995: 84); and making adaptations including adaptive equipment for learners and teachers (Levangie, 1980; Wren & Parkhouse, 1998).

The need for ***advocacy skills*** has also been recognized (Jirikowic et al., 2001; Pollock & Stewart, 1998). Jirkowic et al. describe the need for therapists to be able to lobby to protect the rights and interests of children: “Therapists need to become advocates for children with special needs and their families as well as for services and systems that support a diverse range of individual needs” (Jirikowic et al., 2001: 58).

In summary, the literature indicates therapists need skills to provide both direct and indirect support. There has been a shift from the skills needed for a medical approach to those skills needed to identify barriers to learning and to facilitate learning. In providing direct support therapists need skills to assess individual learners, set functional goals, provide support, evaluate and record outcomes. Therapists need skills to undertake preventive activities. Indirect support requires skills to work with the teachers, in the classroom, with the broader education system, and with the parents; to collaborate and develop a partnership with teachers and parents; to modify the curriculum; to teach, listen to, supervise and evaluate work with parents, teachers and others; to facilitate multidisciplinary and multisectoral collaboration including teamwork, networking, communication; to make appropriate changes to the environment; and for advocacy.

3.3.1.3 Attitudes

Therapists need to demonstrate their ***respect*** for the teachers, parents and assistants, to be able to share what they know with them, "and be willing to enter into a relationship among equals" (Bundy, 1995: 83). They need to show ***empathy*** towards the teachers' concerns (Royeen, 1988) and be able to identify the emotions others are experiencing (Glogowska & Campbell, 2000).

Jirkowic et al. (2001) describe the need for therapists to have "***cultural competence***". This includes "…The ability to honor and respect the beliefs, language, interpersonal styles, and behaviours of individuals and families receiving services, as well as staff who are providing such services" (Maternal Child and Health Bureau cited in Jirkowic et al., 2001: 51). Therapists need the ability to ***listen*** to parent's beliefs about the causes of their child's difficulty/disability and related feelings of guilt in order to help alleviate this (Glogowska, 1998).

Therapists internationally still need to ***believe in their potential*** to provide appropriate and effective support to learners, teachers and others in ordinary schools (New, 1998). They need ***motivation*** to continue learning, and thereby to keep up with contemporary practice and changes (Harn et al., 1999).

Moving away from direct support to indirect support has been difficult because therapists need new knowledge, skills and different attitudes to provide effective support. Therapists internationally find it difficult to find time to plan. There is insufficient collaboration. They report that they have inadequate training on how to work in the classroom. Many teachers in the school do not understand that the therapist's role is to provide indirect support. Parents and teachers prefer direct support (Swinth & Hanft, 2002). There are reports that this new role is taking therapists beyond their comfort zone (Law et al., 2002).

There has been little research reported on the new roles of the therapists with their focus on indirect support and consultation and how effective the outcomes are in addressing

barriers to learning. Niehues, Bundy, Mattingly and Lawlor (1991: 207), however, report that indirect therapy can make a difference to learners. They describe successful outcomes in a qualitative study of therapists who used consultative strategies. In addressing physical and learning problems there was collaboration between team members rather than direct, hands-on treatment with learners. As Paradice and Adewusi (2002) explain effective support is the ability to prepare learners for the world outside of the school walls.

In summary therapists in a number of countries internationally have identified the need for specific and generic competencies related to knowledge, skills and attitudes that enable them to provide both direct and indirect support to learners. To date, though, there has been minimal research to indicate whether and how this has been developed or if the outcomes have been successful.

3.3.2 Competencies of therapists in South Africa

One of the key questions being explored in this thesis is: "What competencies do therapists need to provide an effective support system?" The South African occupational therapy, physiotherapy and speech and language therapy literature does not identify the competencies needed for indirect support for learners in schools. Two documents from the Department of Education refer to the competencies needed by education support services personnel. The NCSNET/NCESS Report (Department of Education, 1997) identifies the need for an education support team that is made up of people who jointly have a broad range of competencies: "Education support teams should include service providers who have the range of competencies that are required" (Department of Education, 1997: 93). The training of the education support personnel will develop skills:

- to undertake intersectoral work;
- to facilitate empowerment;
- to develop the capacity of teachers and parents;
- to acknowledge and celebrate diversity;
- to understand human rights;
- to facilitate community development;
- to build and support the centre-of-learning team.

(Department of Education, 1997: 101)

"The conceptual guidelines for the implementation of inclusive education: District-based support teams" (Department of Education, 2003a), however, emphasises how the local needs will determine the specific competencies that are required to meet these needs. A flexible approach to the provision of support is emphasised with the focus on what particular knowledge or skills is required and not on the professional discipline of the person who is providing the support:

> The principle of flexibility should include a focus on the competencies needed to address particular needs. This is in contrast to an approach that focuses on qualifications and particular professional categories. For example, the 'support' may be 'counselling'. A number of different professional and even non-professional categories could fulfil this role.
> (Department of Education, 2003a: 19)

These Guidelines (Department of Education, 2003a: 25) identify that the district-based support teams need a broad range of competencies. These include the ability to:

- use a systemic approach to the assessment of needs and barriers to learning, including those at the individual level, experienced by the learner and the teacher; within the curriculum; at the school level; and at the level of the broader system, the home environment, the community and the social context
- develop strategies to address these needs and barriers
- develop preventive programmes; identify and build on the strengths of learners and educators; develop a supportive learning environment; identify learners or educators who are "at risk"; implement screening; develop social inclusion programmes
- research what resources are available inside and outside the school to provide support
- monitor and evaluate programmes in the school and in the community
- use "action-reflection" to improve the support services
- facilitate the learning of all learners through the identification of particular learning needs and the development of appropriate learning programmes

- provide expert support for particular "special needs" (e.g. Braille or Sign Language)
- develop materials for particular learning needs
- address particular psychological, social and physical health problems
- develop health promotion programmes
- provide counselling for learners, educators and parents (including stress management)
- train teachers and parents to develop their capacity
- develop teams
- provide conflict management training and facilitation
- develop the curriculum
- adapt learning programmes for particular learning needs
- provide organisational development support to schools to assist with the development of supportive and effective teaching and learning environments
- provide capacity development for school governing bodies, management teams and individuals related to leadership, management and governance
- develop the school's capacity to manage its own finances

The competencies needed by therapists in South Africa are not identified in isolation from those needed by the district-based support team. The Department of Education has identified this broad range of competencies that are required by the district-based support teams to support learners using a collaborative multidisciplinary team approach. It does not specify particular professional job descriptions. In the Western Cape Province the Western Cape Education Department (WCED) in collaboration with the EMDCs are developing these job descriptions. The district-based support team will draw support from many sectors including education, health, welfare sectors, NGOs and the community:

> …parents, grandparents, community-based rehabilitation workers, community organizations, religious organizations, traditional healers, people with disabilities and their organizations, municipal health clinic personnel, private practitioners, higher education institutions, the business sector and various State departments. (Department of Education, 1997: 91)

The Department of Education (2003a) emphasises that, in addition to the training required to develop their specific discipline-related skills, all education support personnel in the district-based support team, including therapists, will need training to develop generic skills. This training would include the development of knowledge and skills in understanding of the process of change; understanding the challenges of providing support; knowing what support is available both within and outside the school; understanding the concept of inclusive education and the changes in attitude needed for it to succeed; identifying and addressing the barriers to learning and development using a systemic approach; skills in adult education, networking, management and leadership development. The development of this district-based support team would be through an action-reflection approach. The development of knowledge, skills and attitude would be addressed through this reflective process.

In summary, internationally, there has been recognition that the introduction of inclusive education has resulted in therapists working in schools needing a broader range of competencies. This includes knowledge, skills and attitudes relating to indirect support to teachers, the school system, parents and the broader community. The competencies that are needed by therapists working in schools in South Africa need to complement those of the others in the district-based support teams. There is a dearth of information on the current roles of therapists and on the competencies required by therapists who work in schools in South Africa. Addressing this gap is the purpose of this study.

3.4 SUMMARY

In Chapter Three I have reviewed the literature related to the move towards an inclusive education system internationally and in South Africa. The changes in policy related to inclusive education were presented, including the shift from mainly identifying problems within the individual learner to a systemic approach of identifying barriers to learning and development. Education support services and their changing role internationally and in South Africa were presented. Finally the competencies needed by therapists for effective support were discussed. The literature highlights a gap in the information

available on the current roles of therapists who work in schools in South Africa and the competencies they require to provide effective support in an inclusive education system. This gap will be addressed through this study. In Chapter Four I present the methodology used in the study.

PART TWO

RESEARCH PROCESS

CHAPTER FOUR

METHODOLOGY

In this chapter, I review literature on the research approach used in my research. This is followed by a detailed description of the procedures used to gather the data. I discuss why it was an appropriate methodology of inquiry to answer the research questions: "What is the most appropriate way for therapists to provide support services for schools in South Africa?" and "What competencies do therapists need to support schools in South Africa?"

4.1 RESEARCH DESIGN

A participatory action research approach using qualitative and quantitative research methodology was used in the study. The selection of the particular research design was based on the phase in the research process. The use of both qualitative and quantitative methods was not for the purpose of triangulation of the data, in a complementary or supplementary way but rather as Strauss and Corbin (1998: 34) describe, to gain insight through "a true interplay between the two". Quantitative questionnaire surveys and qualitative focus group discussions and workshops, using interpretive theories as described by Denzin and Lincoln (1994) and Miles and Huberman (1994), were therefore undertaken.

4.1.1 Participatory action research

I chose to use participatory action research as it is a method of research that allows both research and action. I wanted to contribute towards the implementation of the vision of inclusive education in South Africa and have viewed my research as part of this process. Participatory action research methodology opened up opportunities for me to work closely with the therapists and was used at various stages of the research in an attempt to develop a partnership with the therapists though their active participation in the research process and through gaining an understanding of their frame of reference (Shepard, Jensen, Schmoll, Hack, & Gwyer, 1993). Through involving the therapists in the research

process, I hoped they would be able to accept the need to change the balance of their support from direct support for learners to indirect support for schools.

Action research, as a method of inquiry involving understanding and changing social systems, has been used since the 1940s (Elden & Chisholm, 1993). It is a method of studying organisational or social problems together with the people who experience these problems. It is acknowledged that the central purpose of action research is to change practice (Elliott, 1991; Kemmis & McTaggart, 1988; Morton-Cooper, 2000; Winter, 1989). New general knowledge is generated by solving these practical problems. It involves a cyclical process in which a problem is identified; planning takes place; followed by an intervention; and then evaluation. This evaluation leads to the identification of a new problem and a new cycle of research based on what has been learnt.

Carr and Kemmis emphasise the reflective component of action research defining it as:

> … simply a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices and the situations in which these practices are carried out. (Carr & Kemmis, 1989: 162)

Greenwood and Levin (2003) describe action research as the most appropriate method of research for academics to address problems facing society. It is a way in which researchers can make a meaningful link with the community beyond the university. They argue that action research results in knowledge, theoretical development and social improvement. “Action research does better what academic social science claims to do” (Greenwood & Levin, 2003: 133). It is a method for bringing about social change.

> We define action research as research in which the validity and value of research results are tested through collaborative insider-professional researcher knowledge generation and application processes in projects of social change that aim to increase fairness, wellness, and self-determination.
> (Greenwood & Levin, 2003: 145)

Peters and Robinson (cited in Elden & Chisholm, 1993: 124) identify four features which the analyses of action researchers share: problem-focus, action orientation, cyclical process, and collaboration/participation. Additionally, Elden and Chisholm discuss how contemporary action research differs from classical action research as the cyclical process may continue after the researcher has left. Ongoing change and learning as a result of the capacity development that has taken place during the research cycles is an important goal. This results from increasing self-determination and self-development of the participants and the system that occurs during the process. This is important in this study.

Elden and Chisholm argue that there is no single, simple model of action research. They describe five elements which are currently present in a basic model of action research. Firstly action research aims at scientific enquiry that has an element of solving practical problems. Secondly it is concerned with what is studied, how this is done, who analyses the data and finally who learns from the outcome. Thirdly it is a process that allows the system that is being studied to study itself and in the process to change. This facilitates its capacity to develop. Fourthly the change is aimed at improving society so researchers select problems related to democratic, humanistic values. "Action research is change oriented and seeks to bring about change that has positive social value" (Elden & Chisholm, 1993: 127). The fifth element is that action research is interdisciplinary. Practice is not based on a theoretical framework from a single discipline, but rather it results in theory: "the cause-and-effect explanations of participants in a given context or what has been termed 'tacit knowledge' and 'local theory' rather than 'general knowledge' or 'scientific theory'" (Elden & Chisholm, 1993: 127).

Taking action is a key factor in action research. Bowling (2002: 411) describes action research as: "… a critical, self-reflective, bottom-up and collaborative approach to enquiry that enables people to take action to resolve identified problems". Similarly Morton-Cooper (2000) defines action research in health care as: "…a collaborative intervention in a real-world health care situation to define a problem and explore a possible solution" (Morton-Cooper, 2000: 18). Miles and Huberman also describe the purpose of what they term collaborative action research as: "… to transform the social

environment through a process of critical inquiry – to act on the world, rather than being acted on" (Miles & Huberman, 1994: 9).

Morton-Cooper (2000) describes four different ways the change process can occur: experimental, organisational, professionalizing and empowering. The experimental type of change tests or generates theories related to cause and effect thus changing group dynamics and group behaviour. The organisational type of change is used to bring about strategic change in an organisation, usually a top-down process. The professionalizing approach is described as one that changes and improves practices in the profession. The empowering type of process is described as a bottom-up process that enables those who do not have a say to become a part of the negotiating process. "The empowering type of action research acts on behalf of the unheard to create a forum for voicing their concerns with a view to improving their situation and, ultimately, increasing their share of power" (Morton-Cooper, 2000: 53). One reason for the use of a participatory approach in this study was to allow the voices of the participants to be heard.

Multiple research methods are used in action research (Bowling, 2002; Morton-Cooper, 2000). Although mainly qualitative methodology is used, quantitative surveys may be incorporated, as is done in this study. It is a research method that is having increasing influence. As Denzin and Lincoln (1994: 11) describe: "More action-, activist-oriented research is on the horizon …"

Participatory action research involves the active engagement of the participants in different stages of the research. A more equal relationship and partnership between the researcher and the participants is possible in action research than in other methods of research as the participants become co-researchers (Elden & Chisholm, 1993). In the process they can make sense of their own data in relation to their values and perceptions. There is mutual sharing and learning between the "insiders" or "informants" and the "outsiders" or "researchers".

Participants bring their "selves" into the research – their culture, values and beliefs. Gergen and Gergen (2003) describe this as the "polyvocality" that needs to be explored.

> … we are encouraged … to recognize both within ourselves as scholars and within those who join our research as participants the multiplicity of competing and often contradictory values, political impulses, conceptions of good, notions of desire, and senses of our 'selves' as persons. (Gergen & Gergen, 2003: 595)

Participation is central to the process of change that takes place in action research: "Participation is essential for participants learning how to learn" (Elden & Chisholm, 1993: 129). Nevertheless Elden and Chisholm emphasise that there are usually degrees of participation as it is rarely feasible for there to be full participation. The process in participatory action research is crucial, with data being collected over a period of time to identify the effects of the changes. As Elden and Chisholm state: "In contemporary action research, the process is as important a product as the solution to a scientific and practical problem" (Elden & Chisholm, 1993: 128).

In summary, participatory action research is a self-reflective, scientific method for studying organisational or social problems. It involves action, bringing about change that has a positive social value and, secondly, it includes the participants as partners who learn and change through capacity development and empowerment. It is a process that may continue after the researcher has left.

4.1.2 Qualitative research

Qualitative research has meant many different things at different times in history. In spite of these differences, Denzin and Lincoln (1994) suggest the following broad definition: "Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter" (Denzin & Lincoln, 1994: 2). Qualitative researchers draw on many paradigms, strategies of enquiry and methods of analysis. The methods involve the interpretation of the multiple realities that emerge from the data and the identification of themes. It is a subjective process directly involving the investigator who attempts "to

make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 1994: 2).

Qualitative research is described by Denzin and Lincoln (2003) as an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the humanities and the social and physical sciences. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective and to the interpretive understanding of human experience. At the same time, the field is inherently political and shaped by multiple ethical and political positions. While quantitative research is based on a positivistic philosophical perspective/paradigm, Denzin and Lincoln (1994, 2003) describe how qualitative research has a wide range of traditions using different theoretical paradigms at different historical moments. They list four interpretive paradigms used in qualitative research: positivist and postpositivist, constructivist-interpretive, critical (Marxist, emancipatory), and feminist-poststructural. Miles and Huberman (1994) describe three approaches to qualitative data analysis: interpretivism, social anthropology and collaborative social research.

4.1.2.1 Strengths of qualitative research

The major strength of qualitative research that emerges consistently in the literature is the depth of the insight and the rich data that can be gained from the participants. Denzin and Lincoln argue that "qualitative researchers are more likely than quantitative researchers to confront the constraints of the everyday social world" (Denzin & Lincoln, 1994: 5). Miles and Huberman (1994) describe a major strength of qualitative research as the ability to gain an insight into "real life" through focusing on ordinary events in their natural settings. All the data are collected within a specific social and historical context which influences the interpretation. The influence of the context on the data needs to be acknowledged as giving them "local groundedness" (Miles & Huberman, 1994: 10). The data have the potential to reveal complex concepts through "thick descriptions" (Miles & Huberman, 1994: 10) that ring true and have a strong impact on the reader.

If data are collected over a "sustained period" (Miles & Huberman, 1994: 10) the process and reasons for why things have happened can be observed. It goes beyond the questions of "what?" and "how many?" Additionally, a qualitative study can be flexible with a variety of methods used. The data are considered particularly valuable for understanding the "meanings" of events, processes and structures in the lives of different people and understanding how these meanings connect to their social world. Qualitative data are suggested as the best strategy in the development of hypotheses in the exploration of a new area and can be used for testing hypotheses. Finally, in a particular setting they can also be used to "supplement, validate, explain, illuminate, or reinterpret quantitative data" (Miles & Huberman, 1994: 10).

4.1.2.2 Limitations of qualitative research

Under limitations I discuss two issues that have emerged from the literature: the "researcher and subjectivity" and secondly speaking for the "other".

Denzin and Lincoln (1994) discuss how research can never be value-free while at the same time "the researcher must confront the ethics and politics of research" (Denzin & Lincoln, 1994: 12). Carpenter (1997) and Denzin and Lincoln (1994) emphasise the importance of being conscious of the personal biography of the researcher which results from the individual's personal experience of gender, class, race, culture and ethnicity and which "leads the researcher to adopt particular views of the 'other' who is studied" (Denzin & Lincoln, 1994: 11). As Denzin and Lincoln explain, the qualitative researcher is located within a specific historical period that guides and constrains the study. Beliefs affect how the researcher views the world and his or her actions. This forms the interpretive framework or paradigm within which the research is undertaken.

> All research is interpretive, guided by a set of beliefs and feelings about the world and how it should be understood and studied. Some of these beliefs may be taken for granted, only assumed; others are highly problematic and controversial. However, each interpretive paradigm makes particular demands on the researcher, including the questions that are asked and the interpretations that are brought to them. (Denzin & Lincoln, 1994: 13)

While it is accepted that all qualitative research has a subjective component and is influenced by the researcher, including the researcher's assumptions and perspectives (Shepard et al., 1993), this is not generally acknowledged as being present in quantitative research. However, all research, qualitative and quantitative is linked to our attitudes and our socialisation, even if it is the identification of the research question. It could thus be argued that by acknowledging this subjective element, and the effect of the individual in the interpretation of the findings, in addition to bringing the voices of the participants to be present in the findings through their words, the trustworthiness is strengthened and it may no longer be seen as overly subjective. Thus the researcher needs self-awareness throughout the process. I have shared some of my background in Chapter 1 to explain how it may have influenced the research process and, in particular, the analysis of the findings.

In summary, qualitative research is a subjective process in which the researchers use a variety of theoretical frameworks, methods of enquiry and analysis to gather and interpret their findings. The rich data that can be gathered, which can be used to interpret social experiences, are considered its strength. However, the subjective nature of the interpretation and representation of another person's "voice" needs to be recognised.

4.1.3 Quantitative research

The purpose of quantitative research methodology has traditionally been to measure or quantify the causes and the effects of particular phenomena. It is used to establish the relationship between variables. Unlike qualitative research methodology, the research designs allow the researcher to generalise the findings and consequently "formulate general laws" (Flick, 2002: 2-3). It is an important research method for undertaking descriptive surveys, as were used in this study. Bowling (2002) explains how descriptive surveys that are repeated over a period of time can provide information on social change.

4.2 RESEARCH METHOD

In this section I describe the methods used to gather data. I explain how the data were analysed, and what was done to ensure validity of the quantitative data and trustworthiness of the qualitative data. The section ends with a description of the ethical considerations for this study.

4.2.1 Research aim and objectives

The aim of this research was to develop an appropriate and integrated approach for therapists to support schools within an inclusive and health promoting schools framework in South Africa.

The specific objectives of the research were:

1. To describe the current roles and responsibilities of therapists in the support system for schools in the Western Cape Province.
2. To explore the future roles and responsibilities of therapists in terms of how they could provide support within the framework of the development of inclusive and health promoting schools.
3. To identify the competencies required by therapists to identify and address barriers to learning in schools.

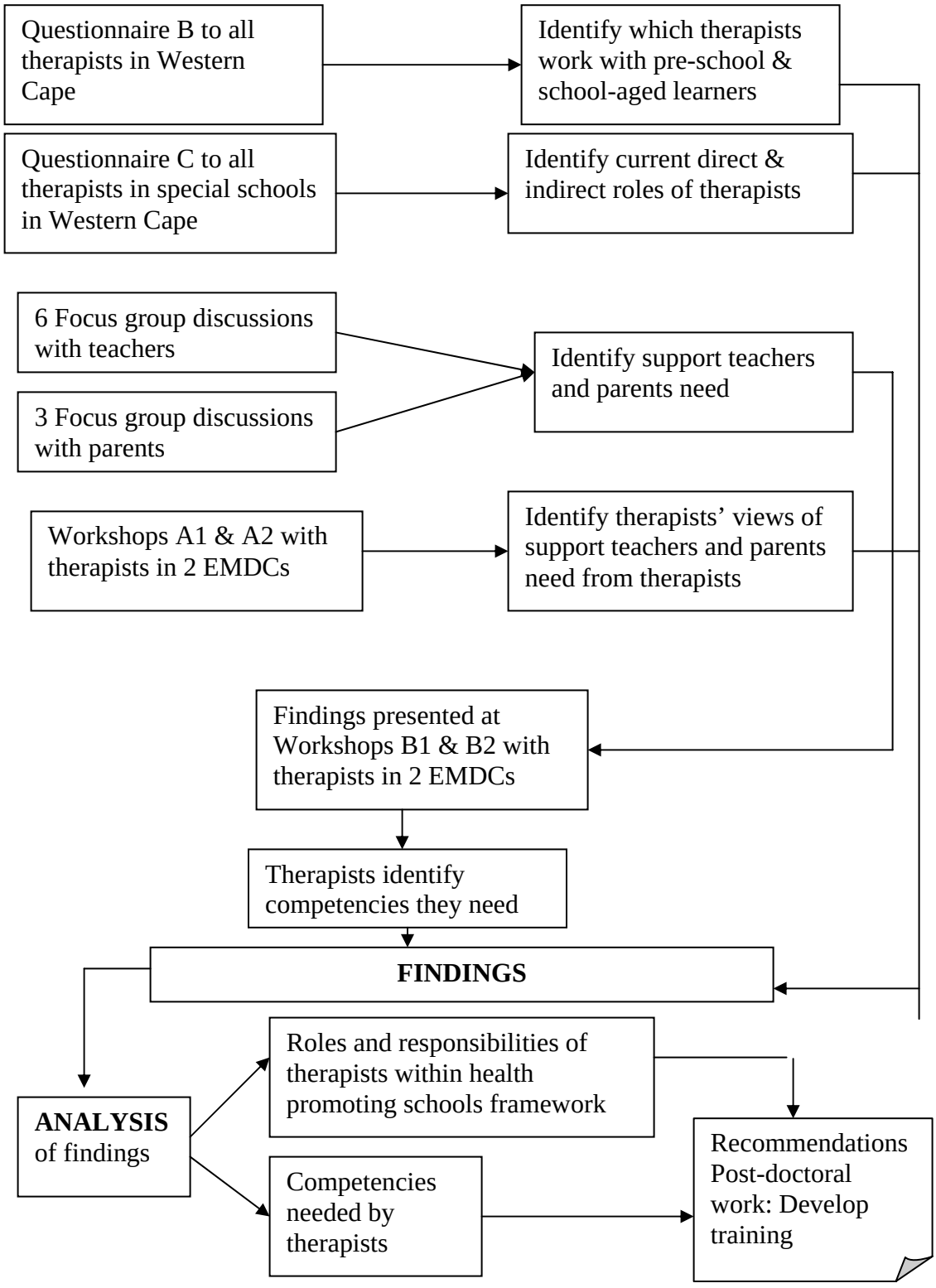
4.2.2 Research setting

The Western Cape Province was selected as the setting for my research as this is the area in which I live. The whole of the Western Cape Province was used for the first two quantitative surveys, while two of the seven education districts in the Western Cape Province were selected for the third quantitative survey and for the qualitative research. The particular education districts were chosen following consultation with the Western Cape Education Department, including the director of Specialised Education Services and other senior personnel. One education district was in the Cape Metropole (Urban EMDC) and the other in a rural area (Rural EMDC). The particular districts were selected because they had special schools in which therapists were employed, as well as people working in the districts with an interest in the development of health promoting schools. The

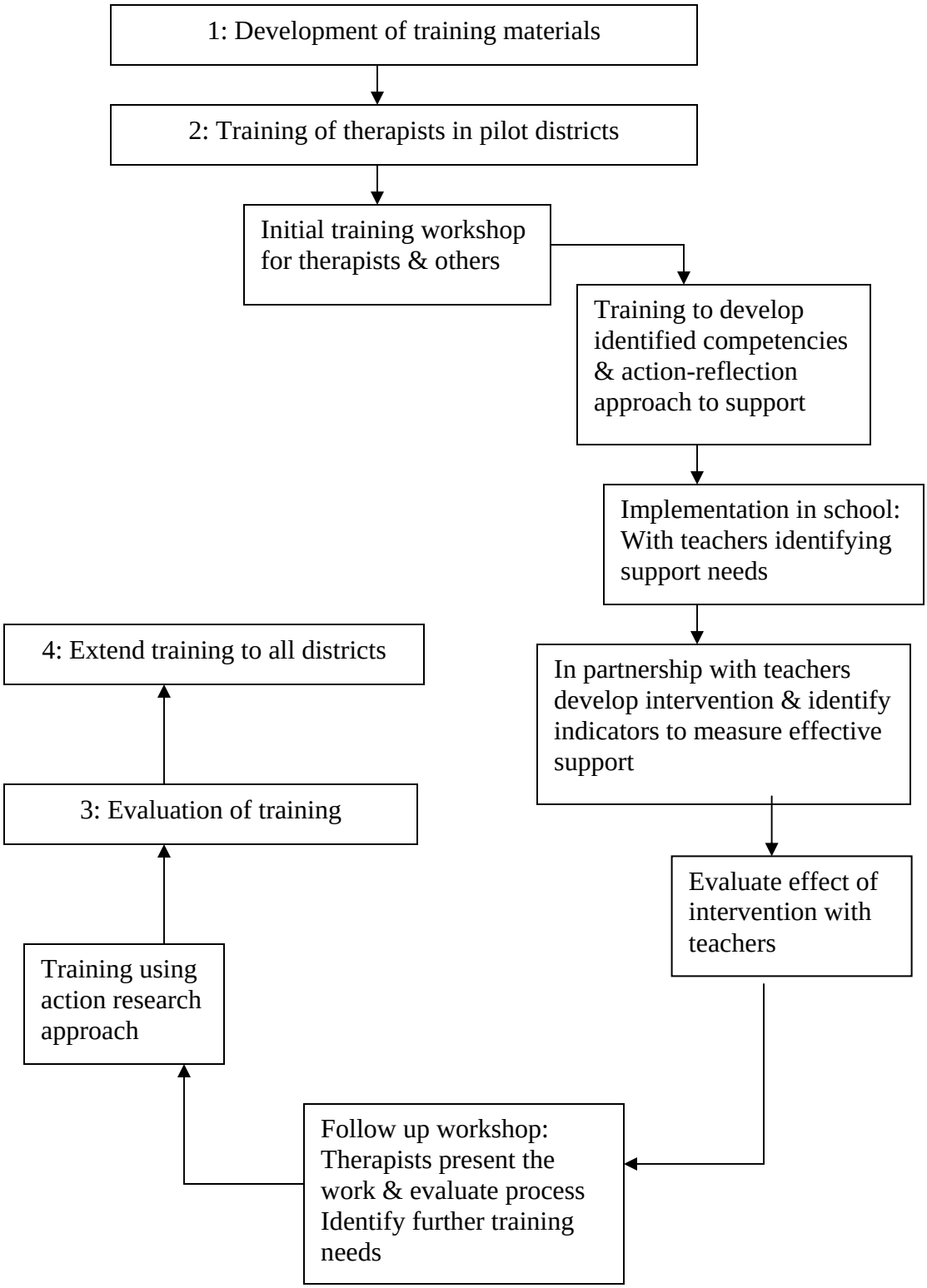
particular schools within each district that were selected for this study included one special school, one “typical” ordinary school, and one school that was actively working towards becoming a “health promoting school” within a “whole-school development framework”. These were chosen in consultation with two WCED senior staff members at the respective EMDCs, both of whom had worked with the Western Cape Health Promoting Schools Reference Group and were familiar with the development of health promoting schools.

The research process is illustrated in Figure 4.1.

Figure 4.1: Participatory action research design
Phase A: This study: Identifying roles & responsibilities of therapists and competencies needed by therapists



Phase B: Post-doctorate: Proposed training of therapists within the district-based support team



4.2.3 Selection of research participants

The study population included all therapists, teachers and parents or caregivers in the Western Cape Province using the process of sampling described by Neumann (1997).

Therapists

The inclusion criteria for the study sample for Questionnaire A (Appendix 1) were therapists who were working in special schools in the Western Cape Province in 2001. All 105 therapists working in the special schools were included.

The inclusion criteria for the study sample for Questionnaire B (Appendix ll) were therapists whose names appeared on the Health Professionals Council of South Africa 2000 register with addresses in the Western Cape Province. A total of 1799 therapists were included.

The inclusion criteria for the study sample for Questionnaire C (Appendix lll) were therapists who were working in special schools in the Western Cape Province in 2001 and private practitioners who were working with pre-school or school-aged learners. All 105 therapists working in the special schools were included and a convenience sample of 12 private practitioners who were selected using snowball sampling.

The inclusion criteria for the study sample for the Workshops were therapists working in special schools in the Rural and Urban EMDC. In the Rural EMDC seven therapists participated in Workshops A1 (Appendix Vl) and five therapists participated in Workshop B1 (Appendix Vll). These were all therapists who had participated in Workshop A1. In the Urban EMDC 20 therapists participated in Workshops A2 and 24 therapists participated in Workshop B2 (Appendix Vll). Workshop B2 included a small number of new therapists who had not participated in Workshop A2.

At the time of the research, all the therapists who worked with learners at the special schools in the Western Cape Province were employed by the WCED or the school governing bodies and were based at the special schools. There were no therapists based at

the EMDCs. The concept of multidisciplinary district-based support teams based at the EMDCs was new and still to be implemented. Each of the special schools functioned independently. There was no coordination of therapy support for all learners within a specific education district, and therapists working in different special schools had little contact with one another. There was, however, one therapist at the Education Department head office who played a co-ordinating and capacity development role at provincial level.

Teachers

The study sample included teachers from the Rural EMDC and the Urban EMDC working in the selected ordinary schools and special schools. The selection of the teachers for the focus group discussions involved a phone call to each of the school principals explaining the purpose of the interview, followed by a letter explaining what would happen in the focus group discussion and requesting for about 8 teachers to volunteer to take part in the focus group (Appendix lX). The principals approached the teachers who then volunteered to participate in the focus group discussions and a date that suited the teachers was decided on using a volunteer sampling method (Polit, Beck, & Hungler, 2001).

Parents and caregivers

The study sample was made up of parents or caregivers of children with disabilities from the Rural EMDC and the Urban EMDC. The selection of the parents or caregivers for two of the groups was done with the assistance of the therapists at the two special schools. At the first special school, using purposeful sampling (Polit et al., 2001), the therapists selected parents or caregivers who, in their opinion, had had both positive and negative experiences with the school system and therapy, hoping variations would emerge so as to enrich the data. The school therapists contacted each person to explain the purpose of the focus group discussion. At the second special school therapists passed on the name of one of the parents to the researcher and using a snowballing method was then used to contact other interested parents (Polit et al., 2001). All these parents were visited briefly, prior to the focus group discussion, to inform them of the purpose of the research. The third group of parents and caregivers were all members of the Disabled

Children's Action Group (DICAG), an organisation of parents and caregivers with children with disabilities. Purposeful sampling was used with a co-ordinator of the organisation, who participated in the focus group discussion, inviting the others to participate.

4.2.4 Research instruments

The research tools included questionnaires and interview guides.

4.2.4.1 Questionnaires

Three different questionnaires were used for the three separate surveys in this study.

Questionnaire A

Questionnaire A (Appendix l) was an open-ended questionnaire asking respondents to indicate the type of support therapists were giving to learners.

Questionnaire B

Questionnaire B (Appendix ll) was a closed-ended questionnaire asking for demographic information to determine the proportion of therapists in the Western Cape Province who worked with and gave support to pre-school learners and school-aged learners. This included closed-ended questions and a map to indicate in which education district the therapists gave support.

Questionnaire C

Questionnaire C (Appendix lll) was a closed-ended questionnaire for a retrospective survey to determine the current roles and responsibilities of the therapists working with learners (Objective 1). It was divided into three sections. The first section was to determine the roles and responsibilities of therapists in providing direct support to learners. The second section was to determine the roles and responsibilities of therapists providing indirect support through their support for teachers, non-teaching school personnel, parents, and the general learner population; developing a supportive environment; support for the curriculum; and community support. The third section was

to determine how the capacity development of the therapists had taken place. The American Occupational Therapy Association uniform terminology related to activities of daily living of 1993, as adapted by the Occupational Therapy Department at UWC (Occupational Therapy Department UWC, undated), was used together with extensive consultation that took place with the therapists (See Section 4.2.5.1). The framework of the questionnaire took the components of the health promoting schools framework into consideration: development of healthy school policy; development of a healthy environment; development of links with the community; development of personal skills; and the re-orientation of the support services. Some questions were closed ended questions, for example to identify which skills therapists developed; others were multiple choice questions, for example to determine the reasons why learners were not referred to other therapists; and others used a Likert Scale, for example to measure who was involved in assessment or evaluation of the learner "always, sometimes or never" or how often support was given to teachers "often, sometimes or never".

4.2.4.2 Interview guides

Interview guides were used for the focus group discussions in this study (Appendices lV and V). In qualitative research the primary research instrument is the researcher who observes, and analyses and interprets the data. However interview guidelines, as described by Patton (1987), are usually used to assist this process. The purpose of using an interview guide was to provide a framework ensuring that the interview would cover similar topics in the different groups. The interview guides in this study were translated into Afrikaans and Xhosa to use with the parents and into Afrikaans to use with the teachers. They included open-ended, broad and non-directive questions. The interviewer did not follow the question sequence in a rigid way, or phrase the questions in exactly the same way each time, allowing a conversation to develop with the participants. Additional probing questions were used for in-depth exploration of the views of the teachers and the parents. The interview guide was developed by the researcher and adhered to more closely by the interviewers when the interviews were conducted in Afrikaans and Xhosa by another person. My background of employment with the WCED was an advantage enabling me to probe more deeply.

The interview guides that were used with the teachers and parents were similar covering the same broad topics, which were based on the need to address barriers to learning at all levels of the education system, home and community (Department of Education, 2003a):

- information about the school or family
- support needed for the learners
- support needed for the teachers
- support needed for the parents
- support needed for the school system
- the link between the school and the community

4.2.4.3 Workshops

Workshops (Appendix Vl and Vll) were conducted with the therapists. These workshops included an information giving or training component in addition to the data gathering component.

The first two workshops (Appendix Vl), Workshops A1 and A2, had three main purposes. The first purpose was to identify what support the therapists thought teachers, schools, parents and communities needed from them. This was done using a focus group discussion with the single guiding question: "What do therapists think the teachers' and parents' need for support is?" The second purpose was to present information on action research as a method of learning through action combined with reflection. This was done through an interactive presentation. The third purpose was to facilitate a practical learning activity related to therapists providing appropriate support for the curriculum.

The second series of workshops (Appendix Vll), Workshops B1 and B2, had three main purposes. The first was to present the information from the focus groups with the teachers and parents or caregivers to the therapists The second purpose was to present the barriers to learning identified in Education White Paper 6, to illustrate how support was needed from therapists at all levels of the education system. The third purpose, bearing in mind the concerns of the teachers and parents, was for the therapists to answer two questions:

- "What support do parents, teachers, the school, and the community need from therapists to prevent and address barriers to learning?"
- "What competencies are needed to be able to provide this support?"

4.2.5 Data collection procedures

Data collection was carried out from 2001-2004 (Appendix Vlll).

4.2.5.1 Participatory action research with the therapists

Therapists were involved at various stages in the research as is illustrated in Figure 4.1.

Identification of need for research on role of therapists

On the 9th March 2001 a focus group discussion was held with five therapists at a special school in Cape Town. The purpose of the focus group was to present and discuss my research proposal and identify the need for research on the changing role of therapists. These therapists recommended that I approach all the therapists working in the special schools in the Western Cape Province.

Development of questionnaires

On 3rd April 2001, following consultation with the WCED, I presented my research proposal to a workshop, organized by the WCED, of all therapists working at special schools. I expressed my hope that they would be able to participate in the research as partners. Following the presentation, the therapists were given Questionnaire A (Appendix l) to complete. This investigated the type of support they were giving to learners. The information from Questionnaire A, in addition to advice from individual therapists from all three disciplines, was used to develop Questionnaire C (Appendix lll). Questionnaires B (Appendix ll) and C were subsequently piloted with the therapists at one of the special schools.

Pilot study

The purpose of the pilot study was to identify ambiguous questions in Questionnaires B and C and to estimate the time needed to answer the questionnaire. The questionnaires

were given to a group of seven therapists, including physiotherapists, occupational therapists and speech and language therapists, at a special school in the Western Cape Province. The researcher was present, answered questions, and interacted with the participants to determine what the clearest way to formulate the questions would be. Following the pilot study, all open-ended questions were removed from the questionnaire; the decision was made to use the term speech and language therapists rather than any alternative term; and questions that respondents found difficult to understand were replaced.

Distribution of Questionnaires B and C

Questionnaire B was posted to all the therapists in the sample with the exception of the therapists who were working at the special schools. A pre-paid, addressed envelope was included to return the questionnaire in. Questionnaire B was combined with Questionnaire C for the therapists working at the special schools. This combined questionnaire was taken to therapists at the special schools in the Cape Metropole and collected from them at a later date. Therapists at schools outside the Cape Metropole were contacted telephonically before being sent the questionnaires and then again later to encourage the return of the questionnaires.

Workshops

Two workshops were held with the therapists in each of the selected EMDCs. Workshops were held with the therapists in the Rural EMDC in October 2003 (Workshop A1) and November 2004 (Workshop B1). Workshops were held with the therapists in the Urban EMDC in November 2003 (Workshop A2) and October 2004 (Workshop B2). The first series of workshops were run jointly with the WCED as a part of the in-service training for therapists. The second series of workshops were run independently of the WCED.

4.2.5.2 Focus group discussions with teachers and parents

Focus group discussions were used to identify the support the teachers and parents need from therapists in order to determine the competencies therapists need to provide support (see Objective 3).

Focus group discussions are one method of collecting data in qualitative research. It is used in action research as participants can feel an active part of the research process. In a focus group discussion an interview takes place with a small group of participants on a selected topic. “The purpose of interviewing, then, is to allow us to enter the other person’s perspective” (Patton, 1987: 109). Bowling (2002), Fontana and Frey (1994) and Patton (1987) describe advantages and disadvantages of using this method of interviews. The advantages include it being inexpensive. There is the possibility for the researcher to hear the views of a much larger number of participants than with individual interviews in the same time period, while still providing rich data. The dynamic within the group is more likely to lead to a discussion focused on the main points, while remaining a method that is flexible in the process of questioning. It becomes easier to identify if participants share the same views or if they have extreme views. Finally, it is a positive, stimulating experience for most participants who can build on each others contributions resulting in richer data. On the other hand there are disadvantages as the number of participants limits how many questions can be asked and the time each participant has to share information. Skilled facilitation is needed to prevent domination of some and to encourage participation of others. Skilled methods of recording the interview are needed. Conflicts may arise within the group and it is not always possible to guarantee confidentiality between participants, so sensitive topics may need to be avoided. It is a process requiring a careful balance between asking questions from the interview guide and following the flow of what is emerging in the discussion. The interviewer is the primary research instrument when conducting focus group discussions. As Shepard et al. (1993: 38) explains: “The primary data-collection instrument in phenomenology is the researcher, who observes, interviews, listens, and records data on spontaneous behaviours”

Six focus group discussions were held with a total of 45 teachers, with groups varying in size from 6-10 participants. The focus group discussions with the teachers took place at the respective teachers’ schools. Three focus group discussions were held with a total of 21 parents or caregivers, with groups varying in size from 4-9 participants. The focus

group discussions with the parents of the school learners were held at their respective schools and the third focus group was held in a room at the local library.

The process of conducting the focus groups was intense. At the end of my first focus group discussion I made a comment in my reflective journal about how relieved I was to have someone else there who was asking the questions so I could observe, absorb feelings and identify where probing was needed. Although I had someone else to facilitate when Afrikaans was spoken, I was able to follow most of the conversation so was aware of what was happening. My Xhosa is far less fluent and it was more difficult to follow and I had to rely on some translation during the focus group. After each focus group discussion I had an hour long discussion or debriefing with the people who had facilitated the groups to identify the impact the interview had had on them. They were frequently concerned that they may not have done it "well enough" and that I may not have the information I wanted. The importance of confidentiality was emphasised.

4.2.5.3 Recording the qualitative data

A variety of methods were used to record the qualitative data.

Audio-recording

The focus group discussions with the teachers, parents and the therapists at the first workshop were audio recorded to obtain an accurate record of what was said.

Note-taking

At the focus group discussions the interviewer took occasional notes to help formulate questions, to make a note of something that needed to be checked out, or as a reminder if probing was needed.

Newsprint

At the focus group discussions, with the exception of the interview done with Xhosa speaking parents, a second person took notes on newsprint in full view of the participants. At all the workshops with the therapists the findings were put onto newsprint in full view

of the participants. This included key phrases, in the participants' words, to enable the participants to have a visual picture of the content of the interview. Participants were encouraged to check whether these notes accurately reflected what they wanted to say.

Reflective journal

Immediately after the focus group discussions I reflected on what had taken place in the course of the interview (Patton, 1987). Reflections focused on the interview process, the group dynamics, how the participants had opened up during the course of the interview and difficulties that had arisen.

4.2.6 Reflections on the process in the workshops

Process is an important component of participatory action research. Snowballing was used throughout the process to meet people in the education and health sectors, in the state and private sectors, and at different levels of the education system. My background in the WCED was invaluable for finding contacts, quickly establishing a working relationship, and facilitating the research process.

Prior to the workshops, in 2003, an opportunity came my way when I was referred to a newly appointed therapist at the WCED head office. We met, discovered a shared vision for inclusive education, and made plans to work together, enabling each of us to reach our objectives. The outcome was that I would become involved in training the therapists working in schools to facilitate the move from direct to indirect support. It was exciting and we rushed ahead, meeting regularly and meeting the therapists in the two selected EMDCs. As a result two "Training Units", based on requests by therapists for skills related to management and skills to support the curriculum, were developed. The training started at Workshop A1 using Unit 1: "Integration of therapeutic tools within the curriculum" (Appendix Vl) in the Rural EMDC. Our plan was that, using an action research model, therapists were to go back to their schools; together with the teachers, to identify a problem related to the curriculum; jointly develop a solution, implement this, and finally evaluate this with the teacher. We planned to evaluate the whole process at a follow up workshop with us at the beginning of 2004. The therapists were excited and

enthusiastic. We anticipated it becoming the tool for change. It was a high point for me as action became more of a reality in the research. Unfortunately, the process collapsed. The therapists found it too difficult to reorganise their work schedules and were unable to follow through with the joint planning with the teachers. In addition, the therapists were too busy to attend any workshop early the following year.

Nevertheless, early in 2004, a similar workshop was held with the therapists from the Urban EMDC. This was less successful. There was criticism from some of the therapists who felt they were inadequately informed about the purpose of the workshop and what was expected of them. Although the criticism appeared to be directed at the WCED, I received the impression that they felt "used" for my research. I responded with an honest written apology (Appendix X): "I haven't always found the research process easy … but I do believe it is one way for as many therapists as possible to have a say in the implementation of the new education system. I would hope we can still work as partners in the future." I included an explanation of the purpose of the research and a proposed plan for how I hoped to proceed. However, it took several months before I was able to re-establish a good working relationship with this group of therapists. As the WCED therapist was not available at this point in time, I chose to run the second series of workshops (B1 and B2) on my own, hoping to appear neutral and not aligned to the WCED. I took a step back from training to an earlier and more necessary step in the research process – identifying the competencies needed by therapists to provide appropriate support (Objective 3).

Immediately before Workshop B2 one therapist approached me to discuss the past difficulties therapists had experienced, indicating that I needed to explain the purpose of the research more clearly and be independent of the WCED, of whom she was very critical. I responded by explaining what I have reflected on to her and subsequently included this in the workshop. The same therapist came to me at the end of the workshop saying it was the first time she understood the role of the therapists in addressing barriers to learning through using a systemic, health promoting approach.

Workshops B1 and B2 were very successful with active participation of all the therapists who attended. One therapist who was unable to attend the workshop wrote to apologise, recommending that, from what she had heard, I present the results of my study at a principal's meeting.

On reflection, I have learnt a lot from this participatory action research process. On the one side there was the WCED with its goal to implement inclusive education and with whom I was collaborating, and on the other side there were the therapists who were participating in the research. I have learnt not to underestimate the value of developing and maintaining a partnership with the therapists; how good relationships are absolutely crucial to the therapists being willing to listen to, and hear, what I have to say. The therapists have trusted me and shared their anxieties and fears with me. I came into the research very critical of therapists for their focus on direct support and have discovered one of the most important things to focus on is to facilitate change is the therapists' well-being so they are willing to develop and use new competencies. This process will help them to understand this need in others in order to develop collaborative partnerships, for example with the teachers.

Although Morton-Cooper (2000) suggests, an essential characteristic of the researcher doing action research is "a thick skin" (Morton-Cooper, 2000: 22), and I have wished at times mine was thicker in the course of the interaction with the therapists, other essential characteristics of action research are empathy and flexibility, which I have integrated into the process.

4.2.7 Analysis of the findings

4.2.7.1 Quantitative data

The data from the questionnaires were analysed using descriptive statistics including percentages and frequencies utilising Microsoft Excel and SAS (Polit et al., 2001). These findings are presented in Chapter Five.

4.2.7.2 Qualitative data

All the data were translated into English and transcribed in full. Problems emerged with early focus group discussions as the quality of sound on the tapes was poor. A better quality recorder was used for subsequent interviews.

The data from the focus groups, workshops and reflective journal were analysed in three sections: the teachers, the parents and the therapists. Each transcript was read several times to identify if any interesting patterns emerged which would illuminate the research questions, the objectives of the research, and the literature that had been reviewed. Reflections were written down as notes in the margin (Miles & Huberman, 1994). A coding system was then applied (Miles & Huberman, 1994; Strauss & Corbin, 1998). This process followed the analysis described by Miles and Huberman. This involved sifting through the codes and reflective notes to identify similarities and differences, and the relationship between these factors. Emerging themes or categories and distinctly different subgroups were identified. Common sequences in the different interviews were recognised. As each set of data was collected generalisations could be identified. It was a process similar to that described by Carpenter: "[The categories] are both constructed by the researcher and abstracted from the language used by the participants" (Carpenter, 1997: 551). This process is illustrated in Appendix XVl.

Denzin and Lincoln (1994: 15) refer to the practice of making sense of the findings from qualitative research as "both artful and political". They continue: "There is no single interpretive truth … there are multiple interpretive communities, each having its own criteria for evaluating an interpretation".

My initial analysis involved scanning the data including the transcripts and the journal entries for significant or interesting events (Strauss & Corbin, 1998). Prior to the interviews I had an expectation that the themes that emerged would be based on the health promotion framework. However, on reviewing the data I made a different decision and the initial themes were based on the barriers to learning experienced by learners as

identified by Education White Paper 6 (Department of Education, 2001). Later these themes were revised again to reflect the needs of the teachers and parents.

Themes from focus group discussions with teachers

Teachers need:

- support to teach a diverse group of learners
- support with the curriculum
- support to identify barriers in the physical environment
- support to accept role changes
- support to make changes to the school system
- support to develop relationships with parents
- support where learners experience major socio-economic challenges
- support to network with the community
- support to develop a positive attitude to diversity
- a supportive relationship with therapists
- training

Themes from focus group discussions with parents

Parents need

- access to education and support for their children
- direct support for their children
- effective means of communicating with their children
- specific competencies to facilitate caring for their children
- emotional support
- advocates to work with them in support of their children
- a supportive community
- a supportive relationship with therapists

Themes from workshops with therapists

The following themes identifying teachers' and parents' needs emerged from the first series of workshops (Workshops A1 and A2).

- Therapists support for teachers
- Relationship between therapists and teachers
- Therapists support for parents
- Therapists' direct support for learners
- Therapists support for the school system
- Therapists' needs for support

Information from the second series of workshops with the therapists was also analysed into themes to identify the support needed by teachers and parents. The competencies identified were grouped into those related to knowledge, skills and attitudes.

4.2.8 Data verification

4.2.8.1 Quantitative data

In quantitative research objectivity is considered an important concept in determining the quality of the data. Reliability and validity need to be taken into account. Reliability indicates the extent to which there is accuracy of the measuring instrument and there is consistency in the measure. This influences the reproducibility of the results (Bowling, 2002; Shepard et al., 1993). Internal validity indicates the extent to which the measuring tool actually measures what it claims to measure. External validity indicates the extent to which the findings can be generalised to other settings (Bowling, 2002).

Questionnaire B was a simple demographic questionnaire and would be reliable if used in another province in South Africa, provided the map was changed to show the education districts in that province. Questionnaire C was developed together with all therapists from the schools in the Western Cape Province. As therapists in the different provinces in South Africa train at institutions which develop similar competencies, it is likely that Questionnaire C would be a reliable tool to use in other provinces in South Africa.

To ensure internal validity, a pilot study on Questionnaires B and C was undertaken prior to their distribution. There was also consultation with individual therapists from the three disciplines in an attempt to ensure the questionnaire was "really measuring what it purports to measure" (Bowling, 2002: 438).

The purpose of Questionnaire B was not so much to be able to generalise to other provinces, and to ensure external validity, but rather to obtain a base line understanding of what is happening in the Western Cape Province. All therapists identified as registered with the Health Professions Council of South Africa were included in the sample. However, the demography of the therapists who work with learners could vary considerably between the different provinces and would make an interesting study in itself.

The purpose of Questionnaire C was to identify the support that therapists in the Western Cape provide to schools. External validity and the extent to which the findings can be generalised to other provinces in South Africa would be difficult as the Western Cape has a much greater number of special schools than most other provinces. This could affect the type of support that the therapists give.

4.2.8.2 Qualitative data

A constructivist interpretive paradigm considers credibility, transferability, dependability and confirmability in place of the positivist criteria used in quantitative research of internal and external validity, reliability and objectivity. Denzin and Lincoln (1994) and Lincoln and Guba cited in Flick (2002) refer to trustworthiness, credibility, dependability, transferability and confirmability as criteria for assessing qualitative research. Ultimately the test of the credibility and validity of my research will be in how it is used. In the words of Greenwood & Levin (2003: 150): "The core validity claim centers on the workability of the actual social change activity engaged in, and the test is whether or not the actual solution to a problem arrived at solves the problem".

Multiple methods were used to add rigor, breadth and depth to the research (Denzin & Lincoln, 1994, 2003). These included focus groups with the parents and teachers and workshops with the therapists; having observers at the interviews and workshops; the use of audio-recording; the use of newsprint to allow the group to visualise their contributions; and a reflective journal. Denzin and Lincoln describe the researcher as the *"bricoleur"* who constructs a solution which changes form as different strategies and methods are used, including those which may not have been in the initial plan. "The researcher-as-*bricoleur*-theorist works between and within competing and overlapping perspectives and paradigms" (Denzin & Lincoln, 1994: 2). "The product of the *bricoleur's* labor is a bricolage, a complex, dense, reflexive, collagelike creation that represents the researcher's images, understandings, and interpretations of the world or phenomenon under analysis" (Denzin & Lincoln, 1994: 3).

Denzin and Lincoln (1994) emphasise that it is not possible to capture objective reality. Research involves interaction between the researcher and the participants. I do not know how my presence or that of my research assistants[3] influenced the stories people told, nor to what extent they were able to trust us, but almost without exception the participants made extremely positive comments about the interviews. These included one from parents: "You have inspired us to start our parent support group again, independently of the school"; one from teachers: "Please play the tape to Kader Asmal" (then Minister of Education); and one from a group of therapists: "Thank you very much for listening to us".

In qualitative research becoming immersed in the data, during collection and analysis, requires a balance between objectivity and sensitivity (Strauss & Corbin, 1998). While objectivity attempts to ensure impartiality and accuracy of interpretation, sensitivity is needed to identify subtle meanings in the data and recognise connections between

[3] i) A female, English speaking colleague with extensive experience in focus group discussions facilitated the first group of teachers.
ii) A female, Afrikaans speaking physiotherapy lecturer facilitated three of the groups of teachers.
iii) A male, Afrikaans speaking senior physiotherapy student facilitated two groups of parents.
iv) A female, Xhosa speaking therapist at a special school facilitated a group of Xhosa speaking parents.

concepts. Complete objectivity is impossible. Strauss and Corbin describe this objectivity as being open and willing to listen, hearing what the respondents have to say, seeing what they do, and understanding while recognising that this understanding is based on the researcher's values, culture, experiences and training. They suggest bias may be reduced by the use of specific techniques including making comparisons, obtaining multiple viewpoints of an event, by stepping back and asking whether the analysis corresponds with the respondent's view, and finally by remaining sceptical. "The procedures of making comparisons, asking questions, and sampling based on evolving theoretical concepts are essential features of the methodology" (Strauss & Corbin, 1998: 46). Sensitivity involves having the insight that is needed to give meaning to the data. "It is by using what we bring to the data in a systematic and aware way that we become sensitive to meaning without forcing our explanations on data" (Strauss & Corbin, 1998: 47). A balance between objectivity and sensitivity is needed throughout the process.

Trustworthiness was increased through the use of multiple methods of data collection as recommended by Carpenter (1997). This facilitated careful recording throughout all the stages of the research. These methods combined using consistent interview guides; audio recording of focus group discussions; keeping field notes; involvement of a colleague as a research assistant for the focus groups and for checking the emerging themes; providing a detailed description of the research process and a profile of the participants; and extensive use of data in reporting the findings.

Is the study reproducible? Strauss and Corbin (1998) argue that although it is not possible to replicate the exact conditions in which the original data were collected, provided the same theoretical perspective is used and the same general rules for data collection and analysis are followed, another researcher would arrive at a similar theoretical explanation for the phenomenon that is being studied using qualitative methodology. In this way substantive theory can be developed. This is a theory that is "developed from the study of one small area of investigation and from one specific population" (Strauss & Corbin, 1998: 267). This theory is able to speak for the particular population and can be applied back to it. The description of the process in this study is extremely detailed enabling

others to use a similar process to identify roles of the therapists and the competencies they require.

4.2.9 Ethical considerations

Permission to conduct the research was initially obtained from the University of the Western Cape. Subsequently the WCED was approached and gave permission for the research to be conducted in the two selected EMDCs (Appendix Xl). After the particular schools were selected the principals were approached and permission to involve the teachers was obtained from them. There was only one school where the principal did not agree to participate resulting in another school in the same EMDC being selected.

All the teachers and parents volunteered to be a part of the particular focus groups. Written and verbal explanations about the purpose of the research were given to them (Appendix Xll). Written informed consent was obtained from the parents and verbal consent from the teachers. The therapists who completed the questionnaires did so voluntarily.

The therapists were present at several workshops that their respective EMDCs or the WCED head office had arranged. Their participation in the research was voluntary. On the occasions that I organised the workshops only those therapists who volunteered were present. Additionally, written informed consent (Appendix Xlll) was obtained at two of the workshops with the therapists, one in each of the EMDCs. At each workshop therapists were informed of how the research was progressing. Therapists were informed that they would be given feedback at the end of the research and that the information would be going to the WCED. Therapists were informed of how the purpose was to assist them in the process of change with the implementation of Education White Paper 6, as the WCED would be informed of the findings and the therapists' views.

Careful attention was paid to the language that the participants, including the teachers, parents and therapists, chose to use. Interpreters were present and the facilitator of each of the focus group discussions was fluent in the home language of the participants. Three

of the focus group discussions with the teachers were in English, one of which was with Xhosa speaking teachers who chose to speak in English, although an interpreter was present, and three of the focus group discussions were in Afrikaans. One of the focus group discussions with the parents was in Xhosa, and the other two in a combination of English and Afrikaans. The workshops were mainly in English with a few therapists speaking Afrikaans.

All participants were informed that they were free to withdraw at any time. All teachers and parents were informed that the purpose of the research was to benefit them, through the provision of the most appropriate support.

Pseudonyms are used throughout the thesis to protect both the participants and the people whose names are mentioned in the raw data.

Copies of the thesis will be made available to the WCED and other role players. The findings of the study have been reported to the therapists at various stages and the final synthesis of the findings will be reported to them. The findings will also be reported to the parents and therapists.

4.3 SUMMARY

In this chapter I discussed the research design and methods used in this study. Participatory action research, using a quantitative questionnaire and qualitative focus group discussions and workshops, was pursued. The research was conducted in the Western Cape Province. Questionnaires A and C were distributed to all the therapists working in schools in the Western Cape; Questionnaire B were distributed to all therapists in the Western Cape Province on the HPCSA register. Focus group discussions with the teachers and parents, and workshops with the therapists, were conducted in the Urban EMDC and the Rural EMDC. The development of the questionnaires and interview guides was presented. The processes of gathering, recording and analysing the data were described. Issues related to verification of the data were addressed. Finally ethical considerations were presented.

The findings of this study are presented in the following four chapters. In Chapter Five the findings describing the therapists' current roles are presented. In Chapter Six the findings of the teachers' needs for support are presented. In Chapter Seven the findings of the parents' needs for support are presented. In Chapter Eight the findings of the therapists' workshops are presented, including therapists' views of the teachers' and parents' need for support and the competencies therapists need to identify and address barriers to learning in schools.

CHAPTER FIVE

FINDINGS: CURRENT ROLES OF THERAPISTS

In this chapter I present the findings of two questionnaires that were distributed to therapists in the Western Cape Province. Firstly, I present the findings related to the therapists' work with pre-school and school-aged children. Secondly, I present information on the direct and indirect support that the therapists provided to learners in school. In this section extensive findings are presented on the roles of the therapists to meet Objective 1: "To describe the current role/responsibilities of therapists in the support system for learners in schools in the Western Cape Province". Finally the findings on capacity development of the therapists are presented.

5.1 THERAPISTS IN THE WESTERN CAPE

At the end of 2001, 1799 copies of Questionnaire B (Appendix ll) were distributed to all therapists on the Health Professions Council of South Africa 2000 register with addresses in the Western Cape Province. A total of 543 completed questionnaires (30%) were returned. This included 70 responses from respondents who were not working as therapists in the Western Cape Province and were excluded from the final study sample. This response rate is low and may in part be the result of an inaccurate register. The 2000 register would at best have updated addresses from 1999. Therapists who changed address after that date would not have received the questionnaire. It is likely that a number of therapists are working in another province or overseas. Cost implications precluded a follow up reminder letter to all therapists and as the questionnaire was anonymous, apart from those therapists who filled in their details, it was not known who had not responded. The remaining 473 responses formed the study sample as presented in Table 5.1.

Table 5.1: Therapists' response to Questionnaire B

Discipline	Questionnaires distributed	Included in sample	
	n	n	
Occupational therapy	590	147	(25%)
Physiotherapy	1012	255	(25%)
Speech and language therapy	197	68	(35%)
Unknown		3	
Total	1799	473	(26%)

In the study sample 31% of the respondents were occupational therapists, 54% were physiotherapists, 14% were speech and language therapists, and the discipline of 1% of the sample was unknown. The percentage of therapists who were employed in the private and state sectors is indicated in Table 5.2.

Table 5.2: Employment of therapists (N=473)

Employer	OT	PT	SLT	Total
	n	n	n	n
WCED post	24	27	21	72
WCED: School governing body post	5	5	4	14
Department of Health	26	28	5	59
Department of Social Development	0	0	0	0
Local authority	2	1	0	3
Private practice	78	204	38	321
NGO / welfare organisation	5	13	4	22
Academic institution	24	32	14	69
Unknown	17	13	3	33
Total				590*

Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist
WCED=Western Cape Education Department; NGO=Non-governmental organisation
*Some therapists worked for both the state and private sectors

The findings indicate that 73% (n=343) of the therapists worked in the private sector, including private practice and the private-not-for-profit sector (NGOs and welfare

organisations). Thirty one percent (n=148) of the therapists worked in the state sector: 18% were employed in the education sector, and 12% in the health sector or the local authority. Within the public sector 58% (n=86) of the therapists worked in the education sector; 40% (n=59) of the therapists worked in the health sector; and 2% (n=3) of the therapists were employed by a local authority.

5.1.1 Therapists working with children

The findings indicated that 74% (n=350) of the therapists worked with pre-school and/or school-aged children. The details are presented in Table 5.3.

Table 5.3: Number of therapists in the Western Cape Province working with learners (N=350)

Therapists	OT	PT	SLT	Total*
	n	n	n	n
Working with pre-school children	93	131	54	278
Working with school-aged children	107	167	61	335

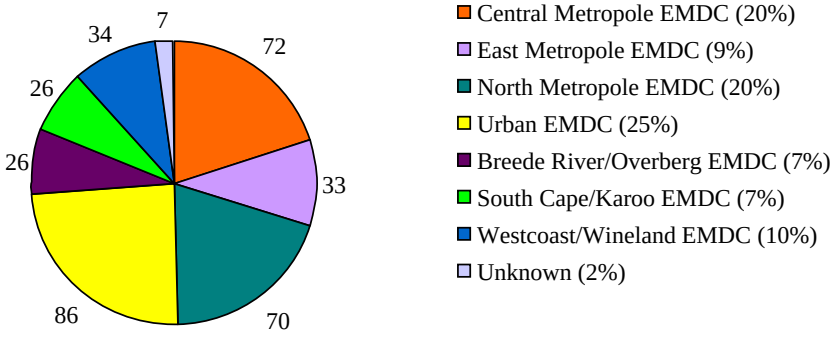
Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist
*Some therapists work with pre-school and school-aged children

There were more therapists, from all three disciplines, who reported that they worked with school-aged children than with pre-school children. The occupational therapists in the sample reported that 63% of them worked with pre-school children and 73% of them worked with school-aged children. The physiotherapists in the sample reported that 51% of them worked with pre-school children and 65% of them worked with school-aged children. The speech and language therapists reported that 79% of them worked with pre-school children and 90% of them worked with school-aged children.

5.1.2 Distribution of therapists working with children per education district (EMDC)

The number and percentage of therapists working with pre-school and/or school-aged children varied considerably between education districts. Seventy four percent (n=261) of the therapists worked with pre-school and school-aged children in the four EMDCs in the Cape Metropole with only 22% (n=86) of the therapists working in the three remaining EMDCs. This is illustrated in Figure 5.1.

Figure 5.1: Number of therapists working with children in each education district/EMDC (N=350)*



Abbreviations: EMDC=Education, Management and Development Centre
*Some therapists worked in more than one EMDC

The therapists indicated that they worked with the learners in a variety of settings including the private and public education and health sector settings listed in Table 5.4.

Table 5.4: Setting where therapists work with learners (N=350)

Setting	Pre-school children %	School-aged children %
Private practice/private hospital	48	57
Special pre-school/school	21	27
Ordinary pre-school/school	13	12
State hospital	10	9
Community health centre	3	3
Day care centre	4	1
Learner's home	4	3
Clinic run by NGO	1	0
Total*	104	112

*Some therapists worked in more than one setting

Forty eight percent of therapists who worked with pre-school learners and 57% of therapists who worked with school-aged learners reported seeing them in a private practice and/or private hospital. This is to be expected with 73% of the sample working in private practice. Only 8% (n=40) of therapists, 85% of whom were private practitioners, saw children in ordinary pre-schools, and 9% (n=43) of therapists, 77% of whom were private practitioners, saw children in ordinary schools. Only one therapist from the WCED worked with children at an ordinary pre-school and an ordinary school. Most of the therapists who worked with learners at special pre-schools or at special schools were employed by the WCED (72% and 76% respectively). A small percentage of the therapists were employed by the school governing bodies (14% in both special pre-schools and special schools). Therapists who worked with learners at state hospitals and community health centres were employed by the Department of Health.

5.1.3 Number of children seen by therapists

Table 5.5 (see Appendix XlV) indicates how the number of learners seen by each therapist in the previous year varied considerably with a range of 1-720 learners per therapist per year. Occupational therapists indicated a range of 1-600 pre-school learners

and 1-300 school-aged learners. Physiotherapists indicated a range of 1-720 pre-school learners and 1-359 school-aged learners. Speech and language therapists indicated a range of 1-200 pre-school learners and 1-200 school-aged learners. The extent of difference in the range may indicate an over estimation in the number of children seen. Alternatively some therapists might have seen learners in groups while other therapists might have seen learners individually.

5.1.4 Summary

The findings of the Questionnaire B indicated that 74% of the therapists in the Western Cape Province who responded worked with pre-school and/or school-aged children. However, 70% of therapists did not respond. One reason for the high proportion of therapists in the education sector was that Questionnaire B was combined with Questionnaire C which was distributed to and collected from the therapists at the special schools (see Section 5.2). Additionally, although the pattern of the distribution of therapists between districts of those who were working with children may be accurate, therapists who worked with children are more likely to have responded to the questionnaire resulting in an overestimation of the proportion of therapists working with children. This makes it difficult to determine the exact proportion of therapists working with children in the Western Cape Province. The proportion of therapists who work for a particular "employer", thus, may be inaccurate with more therapists who work with children having responded.

The pattern of distribution of therapists in the different education districts reflects an inequitable distribution of therapists who work with children, with 74% of therapists working in the Cape Metropole urban areas. Most of the therapists working with children worked in private practice with only 21-27% of these therapists, who were employed by the WCED or school governing bodies, indicating that they worked in special pre-schools or special schools. This reflects the gap in access to therapy services for children between those from wealthier families who, firstly, live in the urban areas, and/or, secondly, have access to private therapy either through personal financial resources or medical aids, and the majority of poor children who have no access to therapy.

5.2 SUPPORTIVE ROLE OF THERAPISTS

At the end of 2001, 117 copies of Questionnaire C (see Appendix lV) were distributed to therapists who were known to be working with school-aged learners. This included 105 questionnaires that were distributed to therapists working in special schools and 12 questionnaires to therapists working in private practice. Of these, 82 questionnaires (70%) were returned, including 29 responses from occupational therapists, 33 from physiotherapists and 20 from speech and language therapists. There were 69 therapists in WCED posts, seven therapists in school governing body posts, four therapists who only worked in private practice (one occupational therapist and three physiotherapists), and two therapists working for the Department of Health at a psychiatric hospital with a school facility, one of whom also worked in private practice. Sixteen percent (n=12) of the school therapists, including nine of the therapists working for the WCED and three therapists in school governing body posts also reported working in private practice.

The support the therapists provided included direct support for the learners, presented in Section 5.2.1, and indirect support, through their support for the teachers, parents, general learners, the school environment and the community, presented in Section 5.2.2.

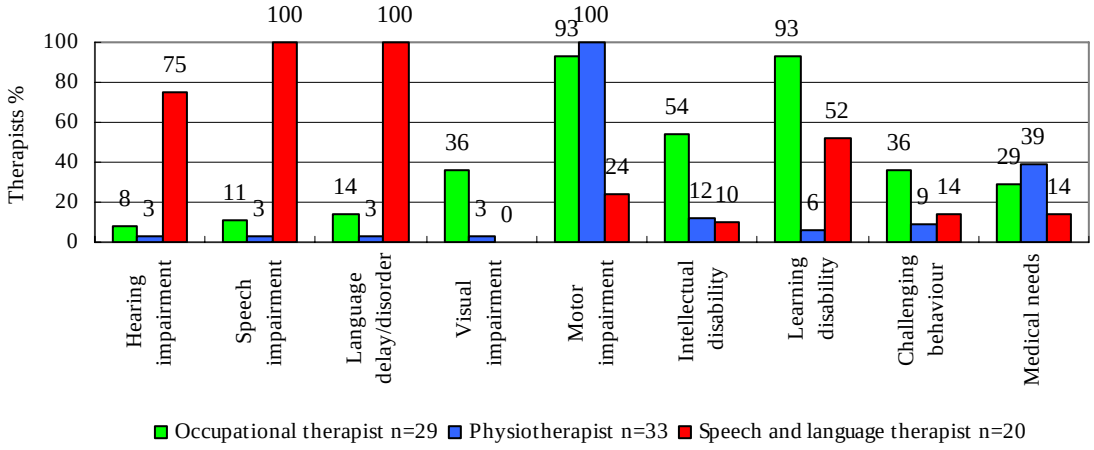
5.2.1 Direct learner support

Direct support in this study includes assessment; intervention, management or treatment; and evaluation of the intervention, management or treatment. All the therapists in this sample were working directly with school-aged learners (7-18years) and 82% were working with pre-school aged learners (3-6years). The therapists indicated that almost all their direct support was provided at the special schools. Only the four independent private practitioners and the two Department of Health therapists did not work in either a special pre-school or a special school. Most therapy was provided in the therapy departments. A smaller proportion of therapists provided therapy in the classroom, on the school grounds or an alternative room in the school. Only two therapists indicated that they provided therapy at the learner's home.

5.2.1.1 Assessment

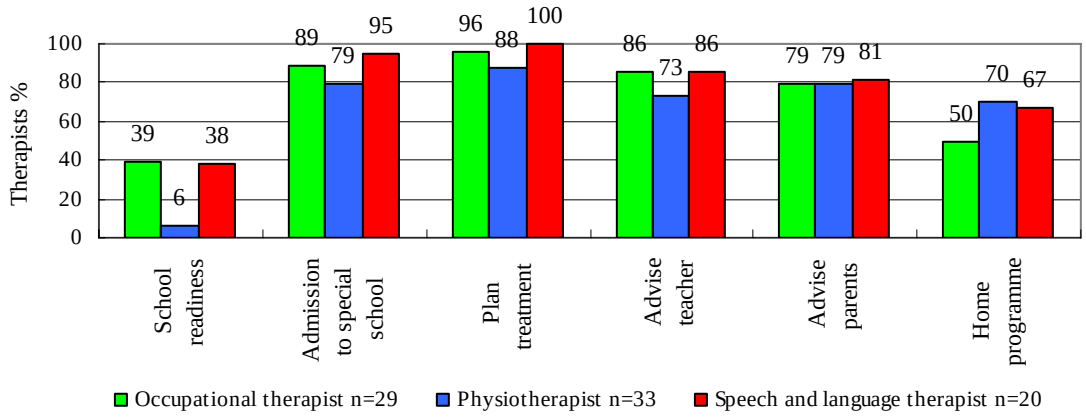
Figure 5.2 shows that therapists from all three disciplines were involved with the assessment of learners with a broad range of impairments or disabilities.

Figure 5.2: Learners with impairments assessed by therapists



Occupational therapists focused on assessing learners with motor impairments, intellectual disabilities and learning disabilities. Physiotherapists focused on assessing learners with motor impairments. Speech and language therapists focused on assessing learners with hearing, speech and language delay or disorders. Figure 5.3 shows the purpose for assessing learners.

Figure 5.3: Purpose for assessment of learners

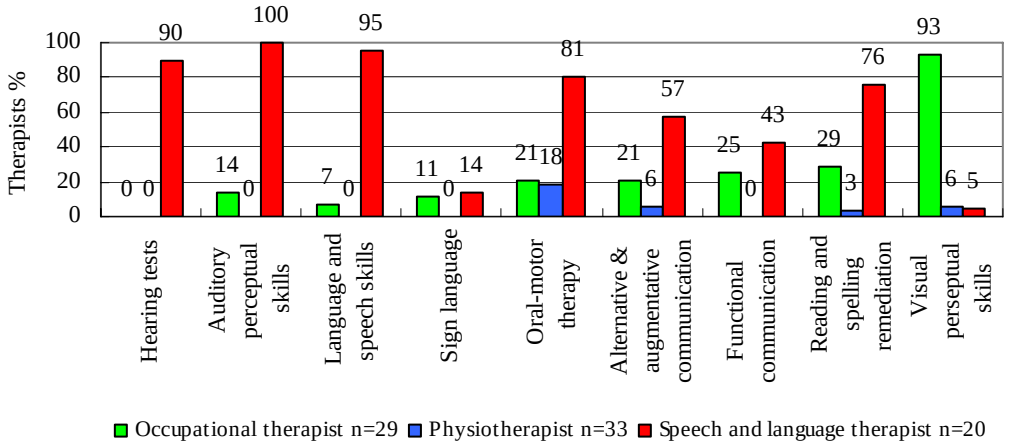


All the therapists indicated similar reasons for why they assessed learners apart from the assessment for school readiness which was done by occupational therapists and speech and language therapists.

5.2.1.2 Direct support intervention, management and treatment

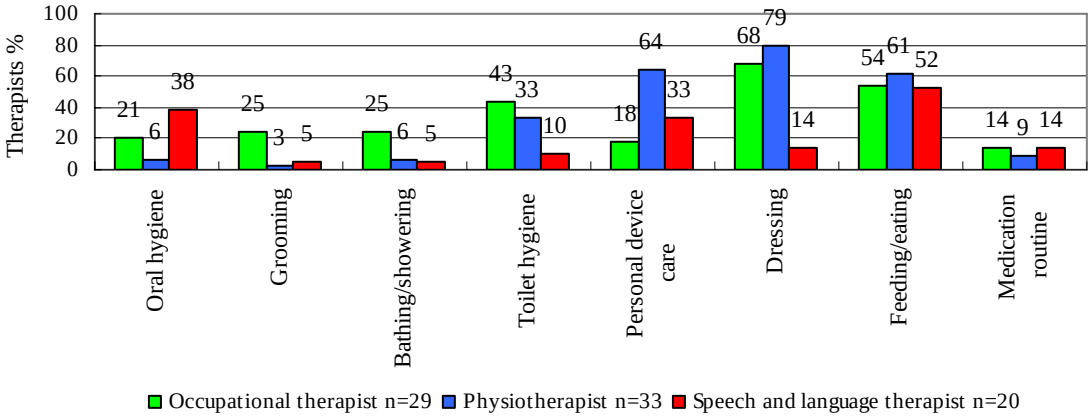
Details of the direct support that therapists provided to develop learners' skills are presented in Figures 5.4 – 5.10. This includes hearing, speech and communication skills; activities of daily living; life skills/social skills; skills in home management; work and productive activities; motor function activities; and play and leisure activities.

Figure 5.4: Hearing, speech and communication skills



Most speech and language therapists provided support for developing the learners' hearing, speech and communication skills. Most occupational therapists provided support for developing visual perceptual skills, with some providing support for the development of communication. Physiotherapists played a minimal role in supporting the development of communication skills.

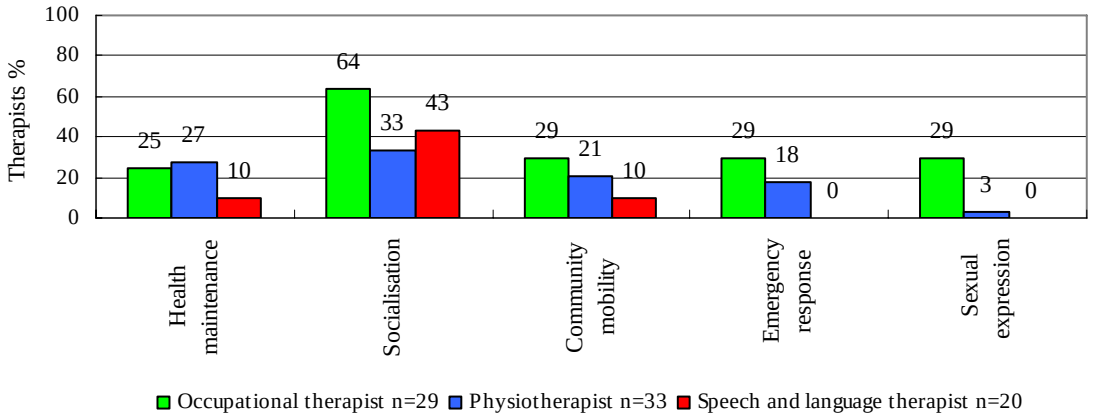
Figure 5.5: Activities of daily living/Self-maintenance tasks



Therapists from all three disciplines were involved in developing the learners' skills for

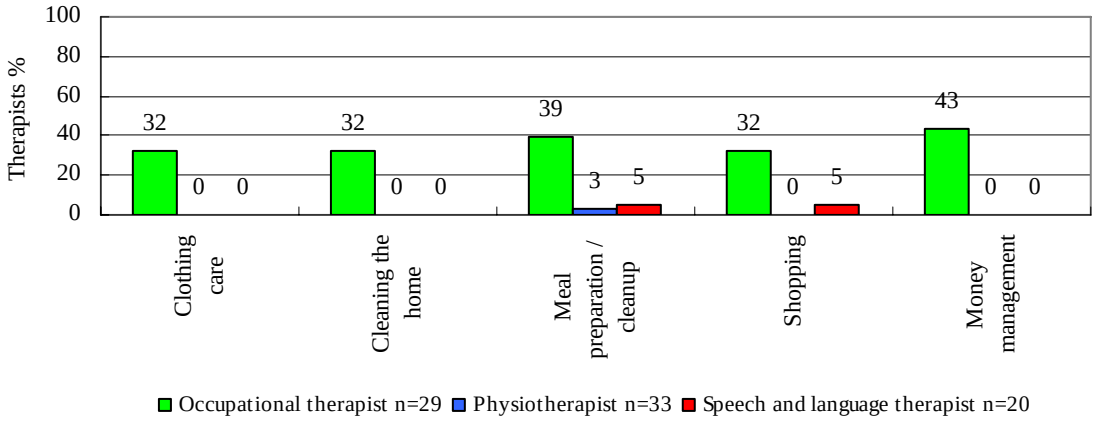
activities of daily living with comparable involvement in the development of feeding/eating skills. In addition, occupational therapists indicated they were involved with the development of a range of skills that included oral hygiene, bathing, using the toilet, and dressing. Physiotherapists were involved in the development of dressing skills and developing skills to enable learners to take care of their personal assistive devices, such as orthotics. Speech and language therapists were involved in developing oral hygiene skills.

Figure 5.6: Life skills/Social skills



Occupational therapists were most involved in a range of life skills development. Speech and language therapists and, to a lesser extent, physiotherapists were also involved in developing socialisation skills.

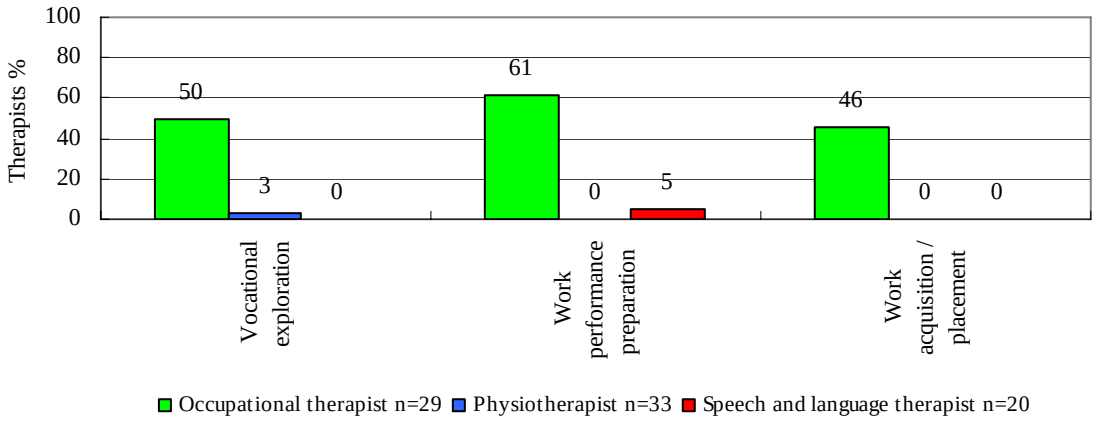
Figure 5.7: Skills in home management



Occupational therapists indicated that they were involved in the development of skills

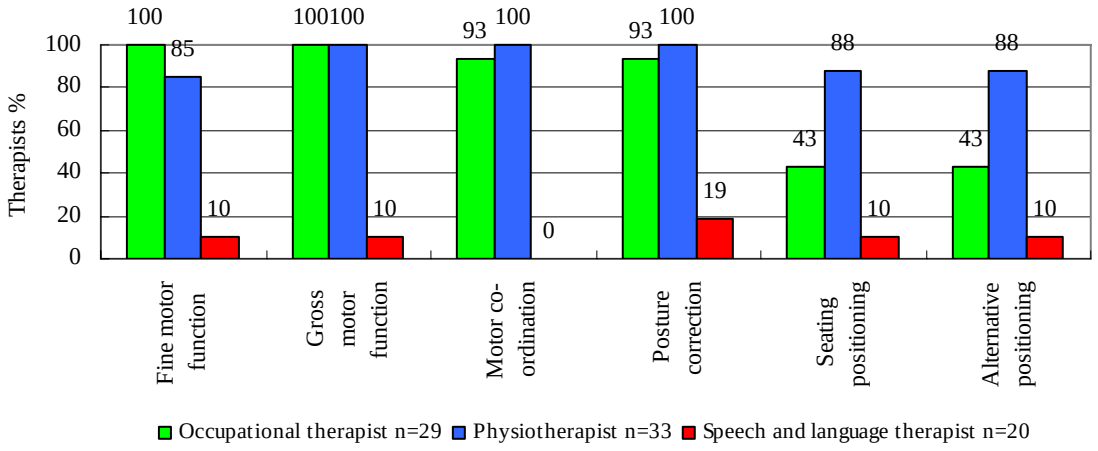
needed at home. These included taking care of clothing, cleaning the home, preparing meals, shopping and managing money.

Figure 5.8: Work and productive activities



Between 46-61% of occupational therapists indicated they were involved in the development of skills learners needed in preparation for the workplace. This involved determining the aptitude of the learners, identifying work opportunities for the learners and developing the learners' skills to apply and interview for a job.

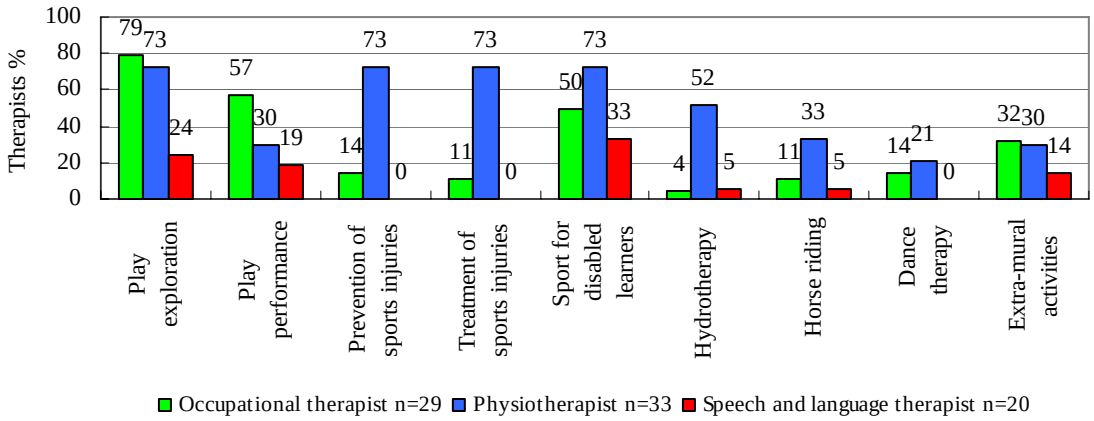
Figure 5.9: Motor function activities



All occupational therapists and physiotherapists indicated that they were involved in developing the motor skills of the learners. This included the development of fine and gross motor skills and motor coordination. Eighty eight percent of physiotherapists, and 43% of occupational therapists, were involved in organising appropriate seating for the learners and making provision for learners to use alternative positions such as lying or

standing. A small percentage of speech and language therapists were also involved in developing motor function skills.

Figure 5.10: Play and leisure activities



Many therapists were involved with developing play and leisure skills. Therapists from all disciplines were involved with sports for disabled learners. Occupational therapists reported that they developed play exploration skills, which included identifying opportunities to play, identifying the learners' interests, and developing play performance skills. Physiotherapists indicated that, in addition to developing play skills, they were involved in prevention and treatment of sports injuries, hydrotherapy and horse riding. A small number of therapists indicated involvement in school extra-mural activities such as choir.

A small number of therapists reported that they were involved in formal counselling of the learners. This included 23% of occupational therapists, 3% of physiotherapists and 10% of speech and language therapists.

Direct support activities were either undertaken with individual learners or with groups of learners (see Appendix XlV: Table 5.6). Occupational therapists and speech and language therapists indicated they worked more often with learners in groups than individually. Physiotherapists indicated they worked more often with individual learners than learners in groups.

5.2.1.3 Evaluation of intervention, management and treatment

The percentage of therapists who evaluated their interventions differed, with 81% of speech and language therapists, 68% of occupational therapists and 52% of physiotherapists reporting that they "always" evaluated their interventions (see Appendix Xlll: Table 5.7). The majority of therapists indicated that they used "regular assessment procedures" to do the evaluation; and assessed whether "the goal was achieved within the proposed timeframe". Seventy six percent of the therapists who did not "always" evaluate their interventions indicated it was because some goals they had set were "very difficult to evaluate". In addition 41% of the therapists indicated that they did not always "set measurable goals" or that there was "insufficient time to do an evaluation".

5.2.1.4 Multidisciplinary support teams

This section reports on therapists' work at the special schools within a multidisciplinary team providing learners with direct support. Most therapists indicated that they worked with other professionals (see Appendix XlV: Figure 5.11). While 97% of physiotherapists and 90% of speech and language therapists indicated working with an occupational therapist, 64% of occupational therapists and 81% of speech and language therapists indicated working with a physiotherapist, only 43% of occupational therapists and 70% of physiotherapists indicated working with a speech and language therapist. This is not unexpected as there are far fewer speech and language therapists in the Western Cape, as indicated in the Health Professions Council Register, and fewer employed in schools in the Western Cape than other therapists.

Additionally, occupational therapists indicated that 39% of them worked with another occupational therapist; 82% with a psychologist; 82% with a school nurse; and 29% with a social worker. Physiotherapists indicated that 24% of them worked with another physiotherapist; 82% with a psychologist; 88% with a school nurse; and 15% with a social worker. Speech and language therapists indicated that 43% of them worked with another speech and language therapist; 95% with a psychologist; 81% with a school nurse; and 29% with a social worker. These findings suggest that psychologists and

school nurses are available to form multidisciplinary teams with, but that there needs to be an increase in either the number of social workers or access to them.

Therapists reported on whom they collaborated with from the multidisciplinary team, firstly, in assessment, including identifying learners' support needs and deciding on intervention/treatment goals, and, secondly, on evaluating the outcome of the support (see Appendix XlV: Table 5.8). On the whole the therapists reported that they made decisions jointly with others more often when they were identifying the support that the learners needed and planning treatment goals than when they were evaluating the outcome of their interventions. The teachers were involved more often than any other person, although only 30% of physiotherapists involved them in the evaluation. Most therapists indicated involving the parents. This pattern was reversed when making decisions with learners, with more involvement of learners in decision making in the evaluation than in the initial planning. Apart from the 70% of physiotherapists who reported involving occupational therapists, fewer than 50% (21-48%) of therapists indicated that they included other therapists in the initial identification and planning. Only 6-36% of the therapists indicated involving other therapists in evaluating the outcome of their intervention. Approximately 40% of therapists involved the psychologists in identifying support needs and planning treatment goals, but only 10-25% of therapists involved the psychologists in evaluating the outcome of intervention. A small percentage of therapists involved the school nurse and very few involved the social worker. Therapists reported that other personnel they involved in making decisions about the learners' support needs and their treatment goals included remedial teachers, mobility instructors, doctors, medical specialists and dentists.

5.2.1.5 Referral of learners to therapists outside the school

Many therapists, including 68% of occupational therapists, 61% of physiotherapists and 62% of speech and language therapists indicated that they refer learners to therapists outside the education system in state hospitals and private practice for more direct support. More therapists referred learners to colleagues in their own discipline than to therapists from other disciplines. Therapists reported that if learners were not enrolled at their school, in addition to referring them to hospital based therapists, they referred the

learners to other special institutions, schools and assessment centres. Some school therapists indicated that severely disabled learners were referred to therapists in private practice for treatment during the long holidays. On the other hand 18% of occupational therapists, 42% of physiotherapists and 33% of speech and language therapists reported that they did not need to refer learners for therapy elsewhere as the school provided acceptable support. Additionally 25% of occupational therapists, 40% of physiotherapists and 24% of speech and language therapists indicated that they did not refer learners to other therapists because the families could not afford the cost of going elsewhere for therapy.

5.2.1.6 Summary

In Sections 5.2.1.1 – 5.2.1.5 data were presented on the direct support therapists indicated that they provided to learners including assessment, intervention and evaluation of the intervention. The extent of the overlap in the intervention roles of therapists from different disciplines is presented in Section 5.2.3.

5.2.2 Indirect learner support

The information on indirect learner support includes the therapists' support for teachers and for the curriculum; support for non-teaching school personnel; support for parents; the provision of assistive devices; support for learners in ordinary schools; support for the school environment including management responsibilities; support for the community; and advocacy.

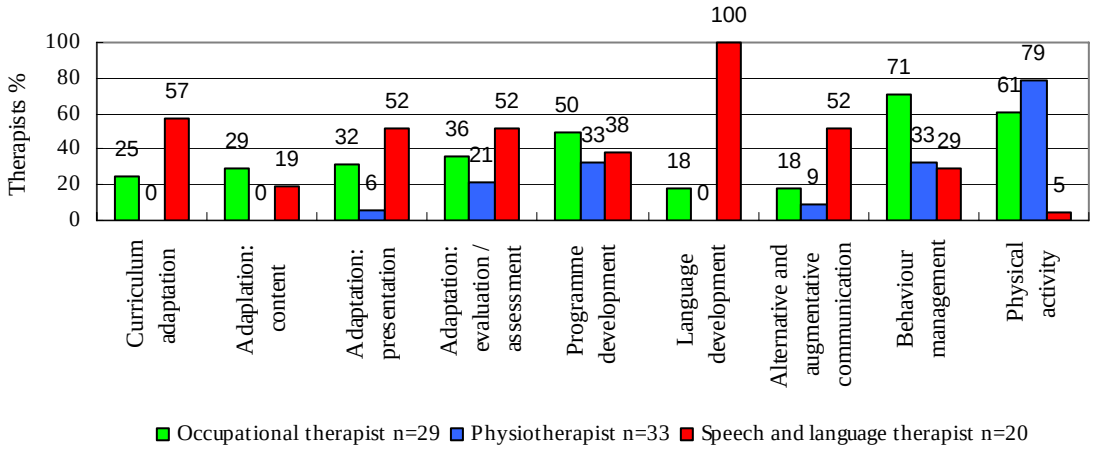
5.2.2.1 Support for teachers

Therapists indicated that support was given to individual teachers and to groups of teachers. Therapists working at the special schools indicated that while most of them gave support to individual teachers fewer therapists gave support to teachers in groups. Very few therapists indicated that they gave the teachers at ordinary schools support, either individually or in groups. A small percentage of therapists indicated that they "sometimes" gave support to the teachers at the EMDCs and to the institution-level support teams.

A high percentage of physiotherapists and speech and language therapists (but only a small percentage of occupational therapists) indicated that they provided the teachers with information on the types of support that therapists offer. This included support for the curriculum; skills development; and provision of information.

The details of how therapists provided support for facilitating access to the curriculum are illustrated in Figure 5.12.

Figure 5.12: Curriculum support



Speech and language therapists indicated more involvement than other therapists in supporting the curriculum including adapting the content; developing alternative ways of presenting the curriculum; and developing alternative ways of evaluation and assessment of the learners. Most speech and language therapists indicated they provided support for the development of the learners' language skills and for using alternative and augmentative communication. Many occupational therapists indicated they taught teachers behaviour management strategies and ways to include all learners in physical activity. Physiotherapists indicated they provided support to include all learners in physical activity. Approximately 40% of therapists, from all three disciplines, indicated that they designed specific programmes for teachers to use with individual learners. However, only 29% of occupational therapists, 27% of physiotherapists and 38% of speech and language therapists indicated that they monitored the support they asked teachers to provide to learners. Therapists from all disciplines, including 32% of

occupational therapists, 30% of physiotherapists and 43% of speech and language therapists, taught teachers techniques to enable specific learners to eat and drink. Eighty five percent of physiotherapists and 32% of occupational therapists indicated that they gave teachers advice on how to lift learners in order to protect the teachers' backs.

Most therapists provided teachers with information on disability and physiotherapists provided information on surgery (see Appendix XlV Figure 5.13). A smaller percentage of therapists provided teachers with information on organisations for people with disabilities but few provided information on the rights of people with disabilities.

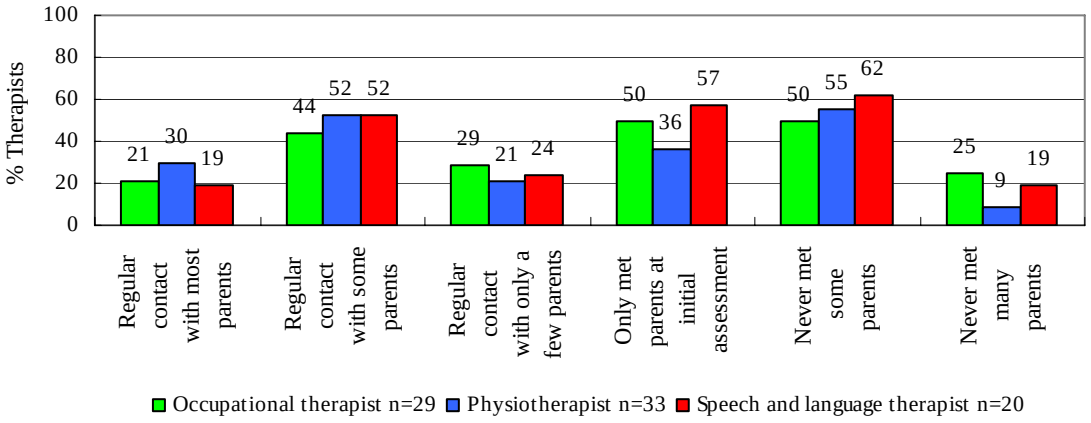
5.2.2.2 Support for non-teaching school personnel

Therapists provided support for non-teaching school personnel (see Appendix XlV: Table 5.9). The majority of therapists (57% occupational therapists, 79% physiotherapists, 66% speech and language therapists) indicated that they provided training for the classroom assistants. Many physiotherapists (73%) and some occupational therapists (43%) and only few speech and language therapists (10%) indicated that they provided training for the bus drivers. A smaller percentage of therapists indicated that they provided training for the hostel personnel (25% occupational therapists, 42% physiotherapists, 29% speech and language therapists). A few therapists indicated that they provided training for administrative personnel (11% occupational therapists, 27% physiotherapists, 10% speech and language therapists).

5.2.2.3 Support for parents

Figure 5.14 illustrates the amount of contact therapists had with the parents of learners attending special schools.

Figure 5.14: Special schools: Therapists contact with parents



The therapists who worked with learners in private practice (n=14) saw the parents of children in ordinary schools more regularly than the therapists in the special schools. Five of these therapists (36%) indicated they had contact with "most of the parents" of these learners on a regular basis.

The therapists' support for parents included support in the home; the provision of information; skills development; and counselling (see Appendix XlV: Figures 15-17). Although the majority of therapists (64% occupational therapists, 82% physiotherapists, 71% speech and language therapists) indicated that they provided home programmes for parents to use with their children, only 43% of occupational therapists, 45% of physiotherapists and 5% of speech and language therapists indicated that they did home visits. Seventy three percent of physiotherapists, 21% of occupational therapists and 33% of speech and language therapists indicated they were involved with liaising with doctors on (behalf of the parents). My personal experience suggests that therapists work closely with doctors, for example physiotherapists with the school doctors and orthopaedic surgeons and speech and language therapists with ENT specialists, who see the learners at the special schools or hospitals, often without the parents' knowledge. Unless surgery

is recommended which will require permission from parents, there may be no communication with the parents around this consultation.

Sixty seven percent of physiotherapists, 18% of occupational therapists and 14% of speech and language therapists reported organising transport for learners to attend hospital appointments (on behalf of the parents). This reflects, firstly, the difficulty parents with children with disabilities have with public transport, secondly, an advantage of being at a special school, and, thirdly, how responsibility is taken away from the parents.

Most therapists (75% occupational therapists, 100% physiotherapists, 90% speech and language therapists) indicated that they provided parents with information on their children's disabilities and 94% of physiotherapists provided information on the children's surgery (21% occupational therapists, 14% speech and language therapists). Fifty seven percent of occupational therapists, 67% of physiotherapists and 5% of speech and language therapists provided information on organisations that are available for people with disabilities. Thirty nine percent of occupational therapists, 24% of physiotherapists and no speech and language therapists provided information on the rights of people with disabilities. In addition a few therapists indicated they provided information on how to obtain a support grant.

Most occupational therapists (75%) indicated they taught parents behaviour management strategies (33% physiotherapists, 43% speech and language therapists) and 95% of speech and language therapists taught skills to parents to develop their children's language (11% occupational therapists, 12% physiotherapists). In addition 36% of occupational therapists, 33% of physiotherapists and 43% of speech and therapists taught parents techniques for feeding their children. Other support for parents, mentioned by therapists, included advice on exercises parents could do with their children; advice on the development of auditory perceptual skills; and the development of reading, spelling and speech skills. Eighty five percent of physiotherapists and 29% of occupational therapists indicated that they gave parents advice on how to lift their children and on back

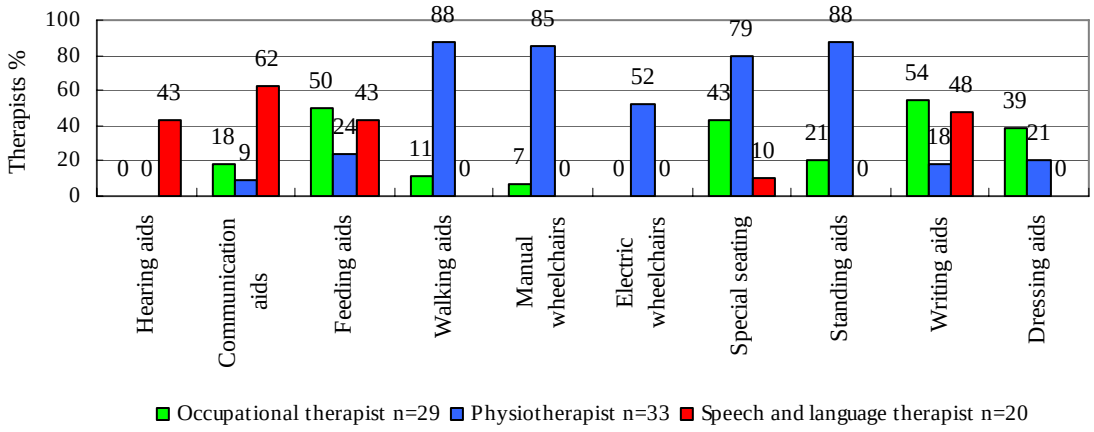
care. Most therapists, including 61% of occupational therapists, 85% of physiotherapists and 76% of speech and language therapists indicated that they gave parents regular reports on their children's progress in therapy.

A few therapists, including 32% of occupational therapists, 15% of physiotherapists and 5% of speech and language therapists, indicated they were involved with the formal counselling of parents.

5.2.2.4 Provision of assistive devices

Assistive devices are provided to learners or teachers to facilitate learning and development. Figure 5.18 illustrates the therapist's roles in providing the assistive devices to the learners.

Figure 5.18: Assistive devices provided to learners



Occupational therapists provided learners with assistive devices for feeding, seating, writing and dressing. Physiotherapists provided learners with assistive devices for walking, standing and seating (including the provision of wheelchairs). Speech and language therapists provided learners with assistive devices for hearing, communication, feeding and writing. In addition therapists provided assistive devices for the school hostels and appropriate seat belts for the school buses.

Teachers and parents are also involved in the provision of assistive devices (see Appendix XlV: Figures 5.19-5.20). Thirty two percent of occupational therapists, 70% of

physiotherapists and 43% of speech and language therapists indicated that they involved parents in choosing the particular assistive devices. Advice was given on appropriate seating and standing, firstly, to teachers (Seating: 43% occupational therapists, 79% physiotherapists, and 10% speech and language therapists; Standing: 21% occupational therapists, 88% physiotherapists, 0% speech and language therapists) and, secondly, to parents (Seating and standing: 61% occupational therapists, 97% physiotherapists, 19% speech and language therapists).

Many therapists were involved in making assistive devices including ear moulds and splints for hands, arms, feet or legs (see Appendix XlV: Table 5.10). Additionally, the majority of the therapists have a role to play in the maintenance (32% occupational therapists, 52% physiotherapists, 38% speech and language therapists) and the repair of the assistive devices (32% occupational therapists, 33% physiotherapists, 19% speech and language therapists) (see Appendix XlV: Table 5.11). Approximately one third of occupational therapists and physiotherapists do the repairs themselves. Advice on the care of mobility devices, including wheelchairs, crutches and orthotics was given, firstly, to teachers (32% occupational therapists, 91% physiotherapists, 10% speech and language therapists) and, secondly, to parents (21% occupational therapists, 70% physiotherapists, 14% speech and language therapists). Over 40% of the speech and language therapists indicated they gave advice to the teachers and parents on the maintenance of the hearing aids and FMs.

Some therapists, including 57% of occupational therapists, 33% of physiotherapists and 48% of speech and language therapists, indicated that they provided teachers with assistive devices to facilitate learning.

5.2.2.5 Support for learners in ordinary schools

Some therapists had given workshops to learners in ordinary schools. This included providing learners with information about disabilities and on the rights of people with disabilities. Therapists were involved with learners from ordinary schools visiting the therapy departments (see Appendix XlV: Figure 5.21). There were a few therapists who

reported that they had contact with ordinary schools to provide screening and assessment for the learners.

5.2.2.6 Support for the school physical and cultural environment

Occupational therapists and physiotherapists indicated that they supported access to the school through making adaptations to the school's physical environment to make it accessible. This included making adaptations to the classroom (54% of occupational therapists and 48% of physiotherapists); the playground (21% and 39% respectively); having ramps or rails installed; and adjusting basins and toilets (see Appendix XlV: Figure 5.22).

The therapists indicated their management and administrative roles (see Appendix XlV: Figure 5.23). This might influence the broader school cultural environment through their roles in school management. Most therapists had administrative tasks, and participated in meetings with other therapists, teachers and personnel from the EMDC. Although 43% of occupational therapists, 39% of physiotherapists and 52% of speech and language therapists indicated being on a school committee, fewer that 7% were members of the school governing body (7% occupational therapists, 6% physiotherapists, 5% speech and language therapists). Nevertheless, 46% of occupational therapists, 36% of physiotherapists and 43% of speech and language therapists indicated they had some influence over policy making in the school. In addition 75% of occupational therapists, 73% of physiotherapists and 76% of speech and language therapists indicated they had responsibilities for fundraising within the special schools with 21% of occupational therapists, 55% of physiotherapists and 33% of speech and language therapists indicating they did fundraising for assistive devices.

5.2.2.7 Support for the community

Many of the therapists, including 82% of the occupational therapists, 64% of the physiotherapists and 62% of the speech and language therapists indicated that they were in the process of developing their therapy departments at the special schools into resource centres. Early identification of problems related to disability was done by 64% of the

occupational therapists, 36% of the physiotherapists and 67% of speech and language therapists (see Appendix XlV: Figure 5.24). Fifty seven percent of occupational therapists, and 67% of physiotherapists and speech and language therapists indicated they provided the community with information on disability and 43% of occupational therapists and 39% of physiotherapists provided information about disabled people's organisations or organisations providing assistance to children with disabilities. Additionally, 29% of occupational therapists, 21% of physiotherapists and 5% of speech and language therapists provided information on the rights of children with disabilities. This was done during open days at the special schools or through talks in the community. One of the four private practitioners provided the community with information on disability and on the early identification of problems. Three of the private practitioners had given talks in the community.

The Department of Education is advocating for the inclusion of people from the community in the provision of support for schools. In spite of this only a small percentage of therapists had made contact with the community based organisations (see Appendix XlV: Figure 5.25). Physiotherapists indicated links with St Giles Sports for the Disabled and the Cerebral Palsy Association and the speech and language therapists indicated links with Interface. Three of the private practitioners had links with these organisations. Seventy one percent of occupational therapists had links to local industry. Only 18% of occupational therapists and 9% of physiotherapists were involved in training community based workers. Volunteers to assist at the school were trained by 21% of occupational therapists, 27% of physiotherapists and 33% of speech and language therapists. None of the private practitioners indicated they had been involved in training community based workers or volunteers.

5.2.2.8 Advocacy

The Department of Education has described the need for the district-based support team to become involved in advocacy with parents and communities on rights within an inclusive education system (Department of Education, 2005). Thirty two percent of occupational therapists, 30% of physiotherapists and 24% of speech and language

therapists, including one of four private practitioners, were involved in advocacy work with parents for children to be accepted into schools. Only 4% (n=1) of occupational therapists and 9% (n=3) of physiotherapists indicated they were participated in local campaigns in the community. Thirty six percent of occupational therapists, 33% of physiotherapists and 14% of speech and language therapists, including one of four private practitioners, indicated they were involved with teachers in ordinary schools advocating for them to accept learners from special schools. Advocacy, an important part of health promotion, is seldom considered health workers' strength. It needs collaboration between therapists, teachers, parents and other community members. This is more likely to happen within a supportive health promoting school setting.

5.2.2.9 Summary

In Sections 5.2.2.1 – 5.2.2.7 data were presented on the therapists' involvement in a broad range of activities to provide indirect support. Most support for teachers was given to teachers working in the special schools. Therapists, particularly speech and language therapists and to a lesser extent occupational therapists, gave support with adapting, presenting and evaluating the curriculum. Speech and language therapists gave support for language development, occupational therapists for behaviour management and both occupational therapists and physiotherapists for physical activity. Non-teaching school personnel were also given training. Parents were provided with information, skills development, home programmes and support with liaising with doctors and hospitals. Assistive devices were provided by many therapists, but particularly physiotherapists. Some therapists had given talks at ordinary schools and in the community. Few therapists were involved in advocacy.

5.2.3 Overlapping roles of therapists

The direct and indirect roles of the therapists were at times clearly "owned by" a particular discipline, but at other times were performed by therapists from more than one discipline. This is illustrated in Figure 5.26.

Figure 5.26: Roles of therapists (as indicated by at least 30%* of the sample)

*Appendix XV shows the separate and overlapping roles of therapists as indicated by different percentages (at least 10%, 20%, 40% and 50%) of therapists.

Occupational therapy – Physiotherapy – Speech & language therapy

Activities of daily living
- feeding and eating

Life skills & social skills
- socialisation

Play & leisure activities
- sport for disabled learners

Support for teacher
- curriculum support: programme development
- information on: disability
- skills development:
  - feeding techniques
  - behaviour management strategies

Support for school
- fundraising activities

Support for learners in ordinary schools
- information on disability

Assistive devices
(provision, maintenance, repair)
- aids for teacher
- advise parents in choosing assistive devices

Support for parents
- home programmes
- information on: disability
- skills development:
  - behaviour management strategies
  - feeding techniques
- involve parents in choosing assistive devices

Support for community
- information on disability
- early identification of problems

Occupational therapy – Physiotherapy

Activities of daily living
- toilet hygiene
- dressing

Motor function activities
- fine motor functional activities
- gross motor functional activities
- motor co-ordination activities
- posture correction
- special seating & alternative positioning

Support for teacher
- curriculum support:
  - behaviour management
  - advise on adapting & promoting physical activity to include all learners
- information on organisations of people with disabilities
- skills taught: lifting techniques

Advocacy
- with teachers in ordinary schools for inclusion

Play and leisure activities
- play exploration
- play performance
- extra-mural activities

Assistive devices
- special seating aids

Environmental support
- adaptations in classroom

Support for parents
- home visits
- advise on home adaptations
- information on organisations for people with disabilities
- advise on seating and standing positions at home

Support for community
- Information on:
  - disabled people's organisations
  - organisations that provide assistance for children with disabilities

Occupational therapy

Hearing/speech/ communication skills
- visual perception skills

Activities of daily living
- oral hygiene

Home management
- clothing care
- cleaning the home
- meal preparation and cleanup
- shopping
- money management

Work and productive activities
- vocational exploration
- work performance preparation
- work acquisition / placement

Assistive devices
(provision, maintenance, repair)
- dressing aids

Support for teachers
- information on rights of people with disabilities

Support for parents
- information on rights of people with disabilities
- counselling

Environmental support
- adaptations: ramps, toilets, basins

Support for learners in ordinary schools
- information on inclusion

Physiotherapy

Activities of daily living
- personal device care

Play & leisure activities
- prevention & treatment of sports injuries
- hydrotherapy
- horse riding

Assistive devices
(provision, maintenance, repair)
- walking aids
- manual & electric wheelchairs
- standing aids

Support for teacher
- information on surgery

Support for parents
- transport learners to hospital
- information on surgery
- Skills: lifting techniques and back care

Environmental support
- adaptations: ramps; toilets & basins; school playground

Speech & language therapy

Hearing/speech/ communication skills
- hearing tests
- auditory perceptual skills
- language & speech skills
- oral-motor therapy
- AAC*
- functional communication
- reading and spelling remediation

Activities of daily living
- oral hygiene

Assistive devices
(provision, maintenance, repair)
- hearing aids
- communication aids

Support for teacher
- Curriculum support:
  - adaptation of curriculum
  - advise on language development
  - advise on AAC

Support for parents
- Skills:
  - language development
  - AAC

Community support
- Training volunteers

*AAC: Alternative and augmentative communication systems

Physiotherapy – Speech & language therapy

Activities of daily living
- personal assistive device care

Assistive devices
(provision, maintenance, repair)
- teach learners to maintain/repair assistive devices

Support for parents
- liaise with doctors on behalf of family

Occupational therapy – Speech & language therapy

Support for teacher
- Curriculum support: adaptation of presentation

Assistive devices
(provision, maintenance, repair)
- feeding aids
- writing aids

Although there is an overlap of roles of the therapists, the different disciplines do have unique roles. The unique area of the discipline specific roles of speech and language therapists was the clearest of the three disciplines – hearing, speech and communication skills. This included their direct support for the learner as well as their indirect support for the teachers and parents. The unique area of discipline specific roles of occupational therapists was home management and work and productive activities. The unique area of

discipline specific roles of physiotherapists was the provision of assistive devices for mobility. There was a great deal of overlap between occupational therapists and physiotherapists in the areas of motor development, activities of daily living and play and leisure activities. The main areas of overlap for all therapists were feeding and sports for disabled learners (both activities that some special schools insist on all therapists being involved in). Many of the other overlapping activities were more general, for example, providing home programmes for parents would need to be done by therapists from all disciplines.

5.2.4 Proportion of time allocated to direct and indirect support

Information on the direct support therapists provided to learners was presented in Section 5.2.1. This was followed by information on the indirect support therapists provided to learners through their support for the teachers, parents, general learners, the school environment, and the community which was presented in Section 5.2.2. Table 5.12 presents the proportion of time the therapists indicated that they allocated to direct and indirect support during the previous year. On reflection, therapists then indicated how they would, if possible, choose to divide their time.

Table 5.12: Percentage of time therapists spend on direct and indirect support (N=82)

Type of support	Present			Future choice		
	OT	**PT**	**SLT**	**OT**	**PT**	**SLT**
Direct support	66	63	74	56	58	64
Indirect support						
• With the teachers	12	9	9	13	9	11
• With the parents	7	8	6	11	11	10
• With the general learners	1	2	1	3	3	4
• changing the environment	2	3	1	3	4	1
• supporting the curriculum	5	6	5	3	5	3
• in the community	2	2	5	8	5	5
Total indirect support	34	36	26	44	42	36

Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Forty four percent of the therapists wanted to balance their workload between direct and indirect support in a different proportion from how they had done it in the past. Eighty one percent (n=29) of these therapists wanted to spend more of their time on indirect support (36% of total). The change they indicated varied between 5-30% (mean: 17%; mode: 10%) increase in indirect support. The remaining 19% of therapists wanted to increase direct support between 10-40%. Forty four percent of the therapists did not want to allocate their time differently. Eleven therapists (13%) did not answer this question fully. It is likely that it was difficult to calculate the percentage of time spent on direct and indirect support over the previous year.

5.3 CAPACITY DEVELOPMENT

In this section I present the findings indicating, firstly, how the capacity of therapists who worked with learners had been developed, and, secondly, how they had facilitated the capacity development of others. The questionnaire included the following definition: *"Capacity development includes various ways to develop yourself in your job. It includes the training, professional development, support and mentoring you are given."* These three aspects of capacity development are presented below: further training, supervision and mentoring.

5.3.1 Capacity development of the therapists

Most therapists indicated that, in the previous year, they had undergone further training for capacity development (see Appendix XlV: Figure 5.27). Training was mostly through short courses presented by specialised therapists (71% occupational therapists, 85% physiotherapists, 90% speech and language therapists) and in-service training by the workplace therapists (54% occupational therapists, 76% physiotherapists and speech and language therapists). About 40% of the therapists indicated that they had received training from the WCED (39% occupational therapists, 42% physiotherapists, 43% speech and language therapists). About 30% of the therapists indicated that they participated in training offered by the professional associations (36% occupational therapists, 33% physiotherapists, 24% speech and language therapists). Twenty five

percent of occupational therapists, 27% of physiotherapists and 19% of speech and language therapists had participated in training offered by the universities while 4% of occupational therapists, 3% of physiotherapists and 29% of speech and language therapists were doing post-graduate qualifications.

Most support and mentoring leading to capacity development were from other therapists either in the same discipline (75% occupational therapists, 82% physiotherapists, 86% speech and language therapists) or from another discipline (75% occupational therapists, 91% physiotherapists, 81% speech and language therapists). Capacity development as a result of support and mentoring by the head of department was indicated by 25% of occupational therapists, 45% of physiotherapists and 57% of speech and language therapists. Capacity development resulting from support and mentoring by the principal was indicated by 29% of occupational therapists, 30% of physiotherapists and 19% of speech and language therapists (see Appendix XlV: Figure 5.28).

5.3.2 Capacity development of others

Therapists indicated that their role in the capacity development of student therapists, medical students, student nurses and student teachers included training, mentoring and supervision (see Appendix XlV: Figure 5.29). Although 71% of occupational therapists, 67% of physiotherapists and 76% of speech and language therapists indicated they were involved with the training of undergraduate student therapists at the special schools, only 14% of occupational therapists and 6% of physiotherapists, including one private practitioner, were involved with training undergraduate students at ordinary schools.

Student teachers, medical students and nursing students may visit the special schools while learning about children with disabilities. Forty six percent of occupational therapists, 58% of physiotherapists and 62% of speech and language therapists indicated that they were involved with the training of student teachers as they observed the therapists at work. Twenty nine percent of occupational therapists, 42% of physiotherapists and 33% of speech and language therapists indicated that they were involved with the training of medical students. Only 14% of occupational therapists, 21%

of physiotherapists and 19% of speech and language therapists indicated that they were involved with the training of nursing students.

In summary, most of the therapists are actively involved in improving their knowledge and skills through further training. Most mentoring is from other colleagues. Many therapists are involved with the supervision, training and mentoring of undergraduate student therapists, and to a lesser extent medical students, student teachers and student nurses.

5.4 CONCLUSIONS

Chapter Five presented the findings on therapists' roles and responsibilities in supporting learners in the Western Cape Province. Questionnaire B was distributed to all therapists in the Western Cape Province with a 30% response rate. The study sample included 473 therapists, consisting of responses from 147 occupational therapists, 255 physiotherapists and 68 speech and language therapists. The majority of the therapists (73%) were working in the private sector. Therapists from the education sector formed 18% of the study sample. They made up 58% of the therapists employed in the state sector who responded.

Seventy four percent of therapists who responded to the questionnaire indicated that they worked with pre-school and/or school-aged learners. They were concentrated in the Cape Metropole, with 75% of the therapists who worked with learners based in the four EMDCs in the Metropole and 25% of the therapists based in the three EMDCs outside the Metropole. The majority of private practitioners worked with the learners at private practices/private hospitals and a few at ordinary schools. The number of children seen by each therapist varied considerably with a range of 1-720 children per therapist per year.

Questionnaire C was distributed to all therapists working in special schools and a few therapists in private practice working with children. These findings included the direct and indirect support provided by the therapists and the capacity development of the therapists.

Direct support included assessment; intervention with individual learners and learners in groups; and evaluation. Therapists reported assessing and working with learners with a range of impairments or disabilities. The focus of occupational therapists was learners with motor impairments, intellectual disabilities and learning disabilities. The focus of physiotherapists was learners with motor impairments. The focus of speech and language therapists was learners with language delay or disorder. The reasons for the assessments included school-readiness, admission to special school, planning treatment interventions and providing support to teachers and parents.

While more than 80% of therapists assessed learners for admission to special schools, the role therapists play in assessing learners for admission to special schools is supposed to change in an inclusive education system as learners are increasingly admitted to their local schools, and teachers take primary responsibility for identifying and addressing barriers to learning. “The core purpose of all assessment within education is to provide effective teaching and learning” (Department of Education, 2003a: 28). The new policy indicates that therapists will only assess learners where teachers have found difficulty identifying and/or addressing barriers, or where children are not yet in the education system and therapists will be advising the parents. The use of standardised tests, as used by some therapists and psychologists for assessing school-readiness and placement, is considered so controversial internationally that it has been recommended it is discontinued in South Africa (Department of Education, 1997, 2005). The ongoing use of standardised tests by therapists will need further investigation.

The direct support provided by the therapists is extensive. It included the development of hearing, speech and communication skills; skills for activities of daily living; life skills; home management skills; work related skills; motor function skills; and play and leisure skills. Occupational therapists indicated that their focus included the development of visual perceptual skills; skills for activities of daily living; life skills, particularly socialisation skills; motor function skills; and play and leisure skills. To a lesser extent they were involved in developing communication skills; home management skills; and

work skills. Physiotherapists indicated that their focus included the development of skills for activities of daily living; motor function skills; and play and leisure skills. To a lesser extent they were involved in developing life skills. Speech and language therapists indicated that their focus was developing hearing, speech and communication skills. To a lesser extent they were involved in developing life skills; motor function skills; and play and leisure skills. A small percentage of therapists were involved with formal counselling of learners. Between 68% of occupational therapists, 52% of physiotherapists and 81% of speech and language therapists indicated that they evaluated the outcome of their therapy.

The findings demonstrate that therapists from different disciplines sometimes provided the same type of support (as shown in Figure 5.26). This overlap in the roles of therapists may in part occur when therapists from a particular discipline are not employed at the particular school. However, the district-based support team needs to be made aware of it when identifying who has the most appropriate competencies to provide specific support.

The frequency of joint decision making with others from the multidisciplinary support team, when assessing and evaluating learners, varied. Guidelines on the role of the district-based support teams in giving support to individual learners have not been clearly spelt out. Multidisciplinary collaboration will not just happen. It will need effective leadership within the EMDCs and, as the Department of Education acknowledges, one of the key challenges to building the district-based support teams is identifying who "needs to be involved in what, and when" (Department of Education, 2003a: 43).

Indirect support has been identified by the Department of Education as the main aim of the district-based support team with a focus on the curriculum and on institutional development (Department of Education, 2003a, 2003b). It is a health promotive form of support, and can be understood within the health promoting schools framework. This includes support for developing personal skills; for strengthening community action; for creating a supportive environment; and for building healthy school policies. For therapists to provide appropriate support for the curriculum they need an understanding of the RNCS to enable them to assist teachers identify and address barriers to learning.

Key to this is the development of the personal skills of the teachers. Likewise the skills of the parents need to be developed. However, the large number of parents who never meet their children's therapists is a matter of concern that must be addressed. Increased contact with the parents would improve the therapists' very limited networking with the community, including community based organisations. Therapists indicated their support for changing the physical environment. The provision of assistive devices by therapists has been effective, though parents need to be more involved in this process. Therapists' involvement in fundraising for assistive devices indicates their commitment to this support. Other support for changing the physical environment could be taken beyond the special schools to local ordinary schools in the education districts. The therapists' indication of support for institutional development and making an impact on the culture of the school includes playing a very limited role on the school governing bodies which have the potential to influence school policy. However, on the whole their role in this and other aspects of advocating for effective inclusion has been inadequate. The indication that most therapists were involved in developing their therapy departments into resource centres, is in line with the education policy, is positive and needs to be supported.

In spite of the criticisms, the findings indicate the extensive roles of the therapists who are currently doing an enormous amount of work that includes many different roles. The direct support for learners at the special schools is often the first time in their lives that many learners with disabilities have had access to therapy, even though it was needed much earlier in their lives. Currently therapists are playing a crucial role in ensuring that learners in the special schools get access to the curriculum. Additionally, many therapists are giving holistic support to learners and their families when there are major socioeconomic difficulties.

Thirty six percent of therapists wanted to increase the proportion of time allocated to indirect support by on average 17% of their working time. This is very little considering the volume of indirect support that is needed. The WCED will need to motivate the 64%

of therapists who did not want to increase the proportion of time on indirect support to make a shift in their roles. Ways of facilitating this will need to be explored.

Most therapists were actively involved in improving their knowledge and skills. If further training is implemented to facilitate the change to a health promoting model of support, it is likely that the type of training they have been receiving needs to change. Most courses offered by specialised therapists, as 71% occupational therapists, 85% physiotherapists, 90% speech and language therapists indicated they had participated in, develop skills for direct hands-on support and not indirect support for the teachers, parents or the school system. Fewer than half of the therapists had received training from the WCED who should be leading this new approach to providing support. It will be difficult for therapists to provide appropriate training to others, including student therapists, unless their own skills in indirect support are developed.

Unfortunately these surveys had two limitations that need to be mentioned. Firstly, due to the very limited response from private practitioners it was not possible to do an extensive comparison on the types of support they offer. Suffice to say that in wealthier areas in Cape Town pre-school and school teachers are recommending private therapy in the form of direct support to many young children whose families can afford it, or perhaps barely afford it.

Secondly, the reliability of the data from Questionnaire C may have been affected by bias. Therapists may not have responded to all questions with correct information on what support they had actually given during the previous year. Their recall was unlikely to have been perfect and this may have led to bias. The findings may reflect selectivity in recall and include activities the therapists believed they “should” be doing, or that were “expected of” therapists from that particular discipline. However, observation of their actual practice was not a realistic alternative in this study.

The following chapter presents the findings indicating the teachers’ needs for support from the therapists.

CHAPTER SIX

FINDINGS: TEACHERS' NEEDS FOR SUPPORT FROM THERAPISTS

In this chapter I present the findings indicating the teachers' needs for support from the therapists. The purpose was to identify the gap between the current support by the therapists and what is needed by the teachers. This was to meet objective two: To explore the future roles and responsibilities of therapists in terms of how they could provide support within the framework of the development of inclusive and health promoting schools. I describe the background of the teachers who participated in the focus group discussions. I then present the findings of the focus group discussions with the teachers in the form of themes that emerged in the analysis.

6.1 BACKGROUND

Focus group discussions were conducted with teachers in six primary schools in the Rural EMDC and in the Urban EMDC. One school in each EMDC was a special school, the second was an ordinary school and the third was an ordinary school that had identified itself as a health promoting school or had been actively involved in whole-school development. A total of 45 teachers participated in the six focus groups with groups varying in size from six to 10 participants. The principals were present for two of the interviews.

The schools were situated in both urban and rural areas. Some had excellent facilities while in others the facilities were more basic. Three of the schools were Afrikaans medium schools, two were Xhosa medium schools and one was an English medium school. There were between 300 and 900 learners in each school. Class sizes in the schools varied from an average of 30 learners/class to 45 learners/class with as many as 48 in a class. The one better-resourced school employed four teacher aides to assist with larger classes.

The two special schools had therapists working at them. In the special school in the Urban EMDC there were full-time occupational therapists, physiotherapists and speech and language therapists but at the special school in the Rural EMDC there were only full-time occupational therapists and speech and language therapists as the Education Department only employed one part-time physiotherapist in the EMDC at the time.

6.1.1 Rural EMDC

School W was an ordinary primary school in a small rural town in the Rural EMDC. It had 895 learners with 22 teachers, and an average of 40 learners/class. Afrikaans was the medium of instruction, with English as the second language, although there were a number of learners with Xhosa as their mother tongue. There was no occupational therapist, physiotherapist or speech and language therapist in the town and there had never been a therapist visiting the school.

School R was an ordinary primary school in a medium sized town in the Rural EMDC. It had 303 learners in 10 classes with an average of 30 learners/class. The school had ten teachers and four teacher aides. Afrikaans was the medium of instruction, with English as the second language. There was no occupational therapist, physiotherapist or speech and language therapist at the school. There were therapists working in private practice in the town and some of the learners had received private therapy. Although not formally a health promoting school, the school had been selected for its involvement in whole-school development.

School N was a special primary boarding school in a large town in the Rural EMDC. It had 63 teachers and 450 learners with approximately 10 learners/class. Afrikaans was the medium of instruction, with English as the second language. There were full-time occupational therapists and speech and language therapists at the school, but only a part-time physiotherapist. The teachers had some experience of working with a physiotherapist at the school in the past.

6.1.2 Urban EMDC

School B was an ordinary primary school in an urbanised area in the Urban EMDC. It had eight teachers with an average of 45 learners/class. Xhosa was the medium of instruction with English taught as the second language. The teachers had no experience of occupational therapy, physiotherapy or speech and language therapy.

School H was an ordinary primary school in an urbanized area in the Urban EMDC. It had 16 teachers and 530 learners with 31-43 learners/class. It was selected as it had identified itself as a health promoting school.

School T was a special primary school in an urbanized area in the Urban EMDC. The school had 21 teachers and 214 learners with 7-18 learners/class. Xhosa was the medium of instruction with English taught as the second language. The school had occupational therapists, physiotherapists and speech and language therapists working at it.

6.2 THEMES INDICATING SUPPORT TEACHERS[4] NEED

The teacher is the key player in the education of the learner. If a learner needs support to be able to learn more effectively, the teacher is the person who needs to facilitate this process. However, to be able to do this teachers need support from others. The themes that emerged indicate the support that the teachers identified they needed.

6.2.1 Teachers need support to teach a diverse group of learners

Teachers described experiences of how they struggled to teach learners with a diverse range of abilities or other differences in the same class.

[4] All names have been changed to protect anonymity.

6.2.1.1 Intellectual and cognitive differences

The differences in learners' intellectual abilities were difficulties that many teachers spoke about. This was mainly in relation to learners with intellectual disabilities. A teacher described her experience:

> *She does not cope well. There is nothing that is sinking into her mind - nothing at all. The easiest word that one child can read ... She can't do that.*

And at another school a teacher described learners in his class:

> *We're now talking of children with an IQ of between 65 and 75. These kids must now be placed in the mainstream and they must be accommodated, and I must tell you honestly that they are not coping very well at all.*

The teacher suggested that inclusion resulted in additional stress for the learner with an intellectual disability in the ordinary classroom:

> *And if you were to remove that child from the class, his stress levels… will be less. Because it puts him under a lot of stress.*

An intellectual disability may make it very difficult for the learner to want to participate in class:

> *I once had a child … this boy was in my class last year. He bunked the classes, and when asked why, he complained that there was too much work done in that class … Tests [were done] and it was found that his IQ was of a child of five-and-a-half years.*

Occasionally teachers spoke of gifted ("intelligent") learners becoming bored in the classroom:

> *But where do you encounter your problems? You encounter them with your intelligent children.*

A teacher in another school described a similar problem with gifted learners:

> *[I have difficulty] with the quick and bright ones because most of your time is spent with the slower and more difficult children and the bright ones get bored very quickly. Ja, and you must also keep them occupied. You just don't always have the time for them as well.*

This indicates that support in adapting the content of the curriculum in addition to the methods and pace of teaching is needed for teachers who work with learners with different cognitive abilities in the same classroom.

6.2.1.2 Language difficulties

At one rural school in the Rural EMDC, teachers mentioned that one of their difficulties was that Xhosa speaking learners were being taught in Afrikaans, as that was the language of instruction of the local primary school. There was no local Xhosa medium primary school.

On the other hand at an urban primary school, parents of learners who spoke Afrikaans at home preferred to have their children taught in English even though their siblings had gone to Afrikaans medium schools. The teachers were concerned that this had a negative impact on the children's ability to communicate fluently in either English or Afrikaans.

Teachers working with Deaf learners spoke of how hard it was for the teachers to communicate with the learners. Teachers spoke of how they had learnt Sign Language in the school, often from the learners, in order to communicate with the learners. The teachers spoke of how there were parents, who did not know Sign Language, who were unable to communicate with their own children.

> *If you don't have knowledge about Deaf children, then you form a completely wrong picture in your mind.*

Other teachers mentioned that the lack of Xhosa speaking education support personnel in the Western Cape Province made it difficult for the Xhosa speaking learners to communicate with people from the education support services:

If we could have more of our people [Xhosa speaking support personnel], that would be great.

This indicates support is needed for teachers who are unable to communicate with the learners; if learners are unable to understand the language of instruction or to communicate; and if parents are unable to communicate with their own children. It also highlights the need for multilingual education support personnel.

6.2.1.3 Reading difficulties

Many learners had difficulties with reading, which in turn affected their ability to learn about different topics they needed to read on as they reached the higher grades:

And right up to grade 7 and right through the high school, everybody is complaining that the kids are unable to read. So because the child is experiencing difficulties with his reading, all his other subjects will also suffer as a result.

This indicates that teachers need support with their methods and the processes of teaching the curriculum, to develop techniques to enable them to teach reading skills at many different levels in the school and not only in the early grades.

6.2.1.4 Medical problems

Some learners had medical problems as a result of infections, including learners with HIV/AIDS. One teacher spoke of how she adapted the demands of the curriculum to suit a learner who had AIDS:

I will beg him to write: "Why are you not writing?" Then he will just explain that he becomes tired, and so I have to accommodate that. So I'm trying all I can."

This indicated teachers need support to understand the medical problems that learners experience and make appropriate adjustments in the demands that are placed on the learners, for example through adjusting the pace of teaching.

6.2.1.5 Emotional difficulties

Teachers were concerned about learners who were teased mentioning this happening to learners who were seen as diverse or different and who could, as a result, become withdrawn:

> *He is not able to pronounce some words properly as a result, and then his little friends at school start to tease him about it. He gets very withdrawn because of the teasing and you have a problem.*

Teachers feared that Deaf learners would be teased by learners in ordinary schools and were concerned about the effect on the learner's ability to progress academically:

> *… because of the teasing and the emotional stress he closes up and doesn't make any progress at school any more. He's unhappy.*

They spoke of the learners with disabilities being exposed to "*many cruelties*" in ordinary schools. Learners appeared to fear diversity with the Deaf learners afraid of those who were able to hear and the hearing learners afraid of the Deaf learners:

> *When we play sport against other mainstream schools our kids [Deaf learners] are kind of scared of other children. The other kids are also a bit scared of our children and this has a psychological effect on our children.*

Teachers spoke of trying to dispel this fear:

> *I say to them: they are the same as you. They only talk with gestures instead of words. They learn the same things at school. But then the children say: "But my mother told me so" … As a result, a lot of kids have the wrong impression of Deaf children.*

Another teacher in an ordinary school spoke of the challenge of working with a learner with a speech difficulty:

> *And the other kids will just start giggling when the child starts to speak. It's not easy for the kid and it's not easy for me. Everybody feels uncomfortable. It must also have an effect on the child.*

They spoke of the emotional difficulties learners who are sent to board at special schools experience:

> *I think one of the biggest reasons for that is due to the trauma they suffer when they are taken away from home.*

Teachers were aware of many learners feeling a lack of self-confidence and described them as reserved and introverted:

> *Sometimes, you must also give the kids self-confidence. Most of the kids can read but they are so reserved and introverted that they have difficulty talking in front of the whole class.*

This indicates that there were times when teachers needed support to be able to give the learners emotional support. The impact of negative attitudes on the learners' emotional well-being and their ability to learn is highlighted in Section 6.2.9.

In summary, in Section 6.2.1, teachers indicate the need for support to enable them to work with a diverse group of learners in the ordinary classroom, including learners with chronic illnesses or disabilities; learners experiencing language difficulties; learners experiencing reading difficulties; learners with medical problems; and learners with emotional difficulties.

6.2.2 Teachers need support with the curriculum

The findings highlighted the support teachers need for different aspects of the curriculum.

6.2.2.1 Adaptation of the curriculum

Teachers spoke of the problems that they had experienced with the RNCS. Their perception was that there was more illiteracy than before:

> *The curriculum 2005 also has its disadvantages in the sense that currently a lot of the kids are illiterate.*

This suggests teachers need support with adapting the content and their methods of teaching the curriculum to ensure that learners can learn effectively. They expressed uncertainty about the lesson preparation needed for Curriculum 2005:

> *There's a big uncertainty with a lot of people when it comes to the lessons and how one should prepare for them.*

They had difficulty with keeping all learners focused on what was being taught and the class activities:

> *Some of these boys, you find that whilst you are busy teaching, they are drawing some pictures. What they like is just to draw pictures rather than doing anything. They'll come during the break and say: "Look what I have drawn." "Where's the homework?" Nothing was done.*

This suggests teachers need support with planning individualised programmes for specific learners and to develop techniques for motivating certain learners to focus on specific tasks. Teachers also spoke of the difficulties that some learners had with writing even though they knew the answers:

> *If you read him a question then he can actually answer you but then you have to write down the answer for him.*

This suggests that teachers need support to find alternative ways of assessing or evaluating the learners. One teacher in an ordinary school spoke of the difficulty she had with identifying how to teach one learner who kept missing school. He was referred to a school psychologist:

> *[The psychologist] found that his IQ was of a child of 5-and-a-half years … I spoke to him [the learner] and told him that if he wants to come back to my class, the door is open for him to come – just for the sake of him to come to school … So I opened the doors for him to come to my class … I must be honest; I just let him do as he pleased.*

Additionally, in some ordinary schools there were learners who were 20 years old who were still in primary school. Their teachers indicated that they thought it was more appropriate to develop the learners' life skills than to follow the standard curriculum:

> *I'm actually preparing them for the community so that they can look after themselves … they are being trained to be self-sufficient.*

Other teachers were concerned that the skills that were being taught were not appropriate for the social circumstances of the learner, indicting the need for support to make appropriate adaptations to the curriculum:

> *They do typing … but many of them don't have computers at home. So I also prepare them for writing skills.*

The teachers who had previously had special classes in their schools were unsure what level of work would be appropriate for learners experiencing difficulties and suggested that easier work was not the answer:

> *I can make the work easier but I can't put that child in the same class …You can't just make the work easier. What about the rest of the class?*

This suggests that teachers need support in identifying the barriers that prevent learning and for planning appropriate teaching programmes. Teachers indicated great concern to provide the best opportunities for the learners, but spoke of the difficulty they experienced doing this:

> *You can't just make the work easier for them … You really have to do something different for them.*

Teachers from schools that had not previously had any special classes appeared far more willing to make changes to the curriculum to ensure that all learners were included at school. They spoke how they developed different levels of work for different learners in their class:

> *You have to do that to accommodate certain learners. Then you go down a certain level where that particular learner can be accommodated. You have to do that. Because you can give that learner a higher level of work, but he or she won't cope. She will just be frustrated. In a way of accommodating, you have to go down and give that learner work that he or she can be comfortable with and do something at the end of the day.*

These findings suggest that teachers not only need support in adapting content, presentation and evaluation of the curriculum so that it is appropriate for particular learners but also the support to enable them to view diversity as an enriching experience for all learners, not simply a challenge.

6.2.2.2 Closure of special classes

There were teachers at one ordinary school who were unhappy with the new education policy, which had led to the closing of special classes in ordinary schools and the inclusion of learners who had previously been in these classes into ordinary classes. This linked with the difficulty they had with making appropriate changes to the curriculum. They described how previously learners in special classes had had their own specially trained teachers, their own individual programmes, and received individual attention. The teachers said these learners were no longer as well prepared for life after school:

> *We had a big special class section. But now, we are sending out a more poorly equipped child from this school than the ones who reach Level Six – the highest level you could reach in a special class in the past.*

The teachers said that this had a negative impact on all learners and "*standards*" could not be maintained. They expressed their concern about inclusion:

> *What will be the best option? To make your strong kids even stronger or to lower your standards so much to accommodate everybody?*

There were also learners who complained when other learners were given work that was on a different level to theirs:

They say: "You always let him get away with that! You don't let us get away with it but you always let him get away with that situation."

There was concern about the learners' academic and technical skills development with learners no longer getting the practical skills they needed to go for further training in a special training school/high school:

The way the system used to be, the kids were taken through the different stages. You could identify him when he arrived in your class. You could then put him through the different stages to build him up until he reached his ceiling. Then you've laid the necessary groundwork for the child to go onto a special school from there.

To learn how to really use your hands doesn't happen overnight. It is something you have to be taught. That child has learnt it from an early age. Jan is now not exposed to it. And the fact that he doesn't get exposed to it at the moment is also another disadvantage of this whole system.

You are five years behind as opposed to the child who has already done five years of it.

The teachers stated that the new areas of learning such as Technology demanded more creativity than learners who had previously been in special classes had:

Ok, that is technology, but technology doesn't help. It's only of use when you deal with kids who are very creative. Somebody who is less creative will still benefit from it, but a kid with no creativity at all is not going to benefit. He is just sitting there and watching everything. The child must have something that he can be proud of. If you just allow him to participate then it's not the same as when he's made something that he can call his own. He wants something that he can say: "I've made this. This is mine".

The mainstream is academic at school, whereas these kids are inclined to be better at practical tasks. He could make something with his hands and then show you with pride what he has made. Instead, he will now only hand in a blank page because the work is of such a standard, no matter how much you try to water it down, the child will throw in the towel because it's beyond him. He doesn't have the guts to carry on. But if he makes a cane basket and the basket turns out skew, he has the guts to take it apart and start from scratch again. So he is able to keep on trying until he has a product at the end that he can be proud of. And at the moment, it's definitely not the case.

This suggests that teachers need support to adapt to the closure of special classes. This is linked to the need for support to adapt the curriculum to enable each learner to develop their creativity to their maximum potential.

6.2.2.3 Special schools

Teachers working with Deaf learners spoke of the importance of having special schools to enable the learners to have access to the curriculum. They were concerned that Deaf children would not be able to manage in ordinary classes because of the size of the classes and the speed at which the work was covered:

> *Deaf school children will never ever be able to function in the mainstream. I mean, the classes are so full and they do things so fast.*
>
> *Even with the curriculum, they [WCED] can't help you. No one has experience of Deaf children. You must just carry on and work something out for yourself.*

This indicates the need for teachers to develop skills, such as Sign Language, to be able to teach learners who have particular needs, such as Deaf learners, effectively. Teachers argued that the environment of a special school was the most appropriate place for this to take place.

6.2.2.4 Administration tasks

The teachers complained about having too many administrative tasks that accompanied the RNCS:

> *Another thing we have a problem with in the Curriculum 2005 is the admin that accompanies it.*
>
> *Apart from just teaching, there is such a lot of admin to be dealt with and forms that have to be filled in that one isn't always able to do all the work that's required of one. You are not able to give the child individual attention. You sit the whole day with forms that have to be completed.*

This indicates that unless teachers get support in the form of additional human resources, possibly assistants or volunteers, they will need support in planning their time to be able to cope with the administrative requirements of the WCED.

6.2.2.5 After-school programmes

Several schools had after-school programmes to assist learners with the curriculum, particularly with reading and writing. However, in some schools this was not practical as learners were bussed to school from the nearby farms so the learners were unable to stay after school, or else parents were not available to give permission for their child to stay late at school. This suggests that teachers need support to organise after-school programmes for specific learners who are struggling.

6.2.2.6 Assistive devices

Assistive devices can play a key role in overcoming barriers in the environment. The teachers working at special schools described this support provided by therapists as useful. The therapists provided assistive devices and advice to assist learners writing; suggested seating positions which made it easier for the learners to participate in classroom activities; and taught the learners, who were unable to speak, methods of communication, for example using the Bliss symbol system, making it possible for the teacher to communicate with the learner. Teachers at one of the special schools spoke of how they needed therapists to assist learners, who were unable to use their hands, for example the provision of head pointers to enable some learners to type. This indicates the importance of providing appropriate assistive devices to teachers and learners.

In summary, in Section 6.2.2, teachers indicate the need for support to adapt the curriculum to enable all learners to learn, including programme adaptation, adaptation for overage learners, disabled learners and learners who had previously been in special classes. They need support to develop after school programmes; to cope with all the administration; and material support in the form of assistive devices.

6.2.3 Teachers need support to identify barriers in the physical environment

The physical environment in all the schools that were visited was well looked after, though the resources that schools had available to them differed enormously. While some schools had large, beautifully maintained sports fields, others had none at all. At many of the schools, regardless of identity as a health-promoting school, learners were involved with recycling. Staff rooms varied from spacious rooms with comfortable chairs to small crowded rooms with wooden chairs around the tables. These were places teachers took pride in, spoke of the curtains they had made, and had decorated the rooms, including displaying schoolwork.

Teachers gave their views on the accessibility of their schools' physical environment. They indicated that they were able to make adaptations to the physical environment to include all learners. All were confident that an arrangement could be made to include a learner in a wheelchair although a number of schools had double-story buildings. At one school, with only a few steps, teachers spoke of the need for a ramp so parents or other community members could get access to the school even if there were no learners in wheelchairs. Learners who had been on crutches were included without difficulty and teachers said they organized other learners to assist as needed.

At one of the special schools the therapists had assisted in the classrooms by making sure all desks and chairs were appropriate heights for the learners. However, a teacher at the other special school said that she had personally brought something in to help strap one of the learners into the chair, as the therapist hadn't noticed the problem:

> *In my class, they measured the height of the desks that we keep the computers on. But they didn't do anything else … I brought the ropes … because they [the learners] are jerking so much. So I had to tie them myself. They [the therapists] didn't come and tell me to do this or that.*

The teachers at this school felt they had not had any help from the therapists with organizing the classroom:

We use our own initiative.

In summary, in Section 6.2.3, teachers indicate they have been able to identify and make the necessary changes to the physical environment to ensure accessibility. However, at times teachers need support to be able to do this effectively.

6.2.4 Teachers need support to accept role changes

Education policy changes have resulted in changes in what is expected of both teachers and therapists. Teachers had questions about their own roles and roles of the therapists. Teachers' views on direct support that therapists provide and early intervention by therapists is presented.

6.2.4.1 What is the teachers' role?

Teachers were anxious about all the extra tasks being demanded of them. This concern was expressed very simply by one of the teachers:

The teacher's work is to teach.

The teachers indicated that the time they had for teaching was being cut because of everything that they were now expected to do. In the schools that had access to therapists – the special schools – the therapists were not seen as a "support" for the teachers in facilitating learning, but as adding to their already heavy load. Teachers in special schools were concerned that tasks they felt belonged to the therapists were being passed on to them:

> *I must just say that as teachers, we do our utmost. We are not only teachers, but we are also physiotherapists, speech therapists and occupational therapists … and psychologists … Maybe we should get their salaries too. The work that the teachers must do is of such a nature that we should get paid for it as well.*
>
> *Which means the therapist must pass on the knowledge to us … but where does one get the time to accommodate all of these things? The bottom line is that you*

don't work on certain apparatus unless you have specialist knowledge. That was told to us in no uncertain terms.

This change in the teacher's role was also a concern expressed in one of the ordinary schools, who felt that additional roles were being demanded of them:

So we will have to be physiotherapists and occupational therapists as well.

Teachers in the special schools said that in spite of the teachers taking on these extra responsibilities, management still gave the therapists the credit:

We do 20 percent and the therapists do 80 percent. But in the yearly report only the therapists are given credit for the children's success. I feel very unhappy about that.

Nevertheless, teachers at some of the ordinary schools were very keen to learn more from the therapists as they felt their own resources were depleted:

If we could only get more things that can show us how we are supposed to help the kids. It could be something very easy or very simple because one doesn't always notice it oneself.

This highlights the teachers' anxieties resulting from having additional roles and responsibilities related to giving learners extra support, putting increasing demands on their time and reducing the time they had to teach. This suggests that the teachers need support to cope with different responsibilities and diverse learning needs, however, the support must not be an add-on type of support but integrated into their work to make teaching easier and more effective.

6.2.4.2 What is the therapists' role?

Teachers at both special schools, working with therapists, spoke of how they were not clear what the therapist's role was:

So we don't know the therapist's jobs … What is their job description?

They said they did not know the difference between the work done by the occupational therapist and the physiotherapist. Teachers in ordinary schools were even more confused. They were not sure what therapists did with the learners:

> *We never get any feedback on what's been done for the child … As a result the teacher is left in the dark.*

Teachers said they could do more to support the learner if they knew what the therapists did with the learners:

> *We would like to know what you [the therapist] do with the children so that we can complement that in our class as well. We could reinforce it you know.*
>
> *You [the teacher] could pay attention to his particular problem if you know what's going on.*

This indicates that teachers need to know what the therapists' roles are and what the therapists do with the learners. They need to understand how to utilise the therapy in the classroom.

6.2.4.3 Direct support

The teachers wanted the therapists to continue to provide direct support. Teachers felt the traditional direct hands-on therapy was valuable for the learners and wanted the therapists to provide support in this way. Many of them wanted the learners to be withdrawn from the class for this therapy as they said it would be more beneficial for the learners. Others said that it was disruptive for the therapist to be in the classroom or that the classroom was too small for the therapist to work there. Their view was that the therapists had their own physical space that they could use.

Where learners had more severe physical disabilities teachers wanted more therapy, as they felt this would reduce the severity of the disability and make it easier to include the

learner in the classroom activities. In one special school where the older learners received less therapy the teachers spoke of how some children were becoming *"stiff"*.

The approach used by some therapists had changed towards indirect support for the learners, through support for the teachers, and some teachers missed the direct support learners had previously received. One teacher expressed her dislike of indirect support for the teacher where the therapist had given the teacher a programme to carry out with the learner:

> *And I don't care if the therapists are brown or white or even black, they must do their own work as well. As a teacher, I'm very busy with my other learners and can't spend a lot of time with a child who has had a programme worked out for him by the therapist – but I must see that he sticks to the programme. So I told her that I knew exactly what she was up to and that I didn't have time to spend with that child. The therapists have the skills and it is their responsibility. What happens to my other seven kids while I am busy with this one? So I took the therapist and showed her the roster. Here is the kid and you will take him for his class on Tuesdays. They easily give their work to you if you are not careful. At the end of term, the principal gets a report that says that they have done all the work. I'm not doing it any more. If a person gets angry with me or whatever, I'm not doing it any more.*

Teachers felt that therapists could manage their time with the learners more effectively in order to ensure the learner received direct therapy:

> *I feel the therapists aren't using the time allocated to them in a very effective manner. They very easily skip a class. And I feel you can perhaps miss one period of literature, but a therapist mustn't skip his or her work with a child. That is very important especially to a disabled child. Because if a child's therapy is neglected like that, then it doesn't help me to try and educate that child from my side. The child needs that boost that he gets from a therapist.*
>
> *Then there is a cut-off date with the occupational therapy. Look, the children have only a certain amount of classes and then it depends on how many kids there are as well. And now the kids get to Grade Three and then they still have those difficulties. They didn't work together enough and they only deal with a certain age … Ja, there's a cut-off date when they feel the kid has reached its full potential … but if the child hasn't overcome all these things, then a way must be found to help him to do so.*

Teachers recognized that there was a shortage of therapists in the special schools and with an increased number of more disabled learners being accepted in the schools it made it difficult to spend as much individual time with learners. However, they felt this had a negative impact on the development of the learner:

> *And another problem that I have is that in the first year classes we don't have a physiotherapist. Luckily the one … is helping us out at the moment. But if the kids don't get their [therapy] regularly, they get stiff. They can barely lift up their feet because they don't get their regular exercises. I can't do it because I'm not trained for it.*

Although this school had a part-time physiotherapist, the learners in the pre-school did not have access to her:

> *And the physiotherapist works with the [primary school] teacher's kids exclusively. But in the pre-primary there are also cerebral kids [learners with cerebral palsy] who don't get [therapy] who could also benefit from it. Ja, who can benefit because they are still young. They are between three and five, and they are not getting any exercise. And at the end of the day, they also end up with the teacher and their muscles are stiff. We must have a physiotherapist because we are not able to help those kids.*

Teachers were very critical of therapists and said they needed to broaden their roles:

> *We as teachers have to play all those roles from speech therapist to psychologist. If they can give us all these roles, then they can also put themselves down for some roles. But they don't want you to even touch the role that they are playing themselves. They get very upset if you want to interfere with their role in any way. They should also broaden their roles like we have to. That way, there will be more contact with us, the educators, and have more contact with the children. But they sometimes appear to be untouchable. We can't interfere with their roles.*

At one ordinary school teachers said they would like support for learners with physical disabilities having had some experience of learners getting physiotherapy for sports injuries. Teachers at another ordinary school did not felt there was a role for physiotherapy in the school:

> *I don't think we really have kids that could benefit from physiotherapy in such a way that it will help them scholastically … If you have expert knowledge, then you can look out for it. You can identify A, B and C for physiotherapy. I mean we don't have knowledge about it. We don't know how to approach a child or what to look for. And like she's said, the child with those problems as a rule also struggles financially and won't react to the recommendations of a physiotherapist.*

However the teachers at the same school felt occupational therapy might be able to help learners who were having emotional problems in the boarding school:

> *I think they can benefit from things like occupational therapy or whatever. They usually are very unstable.*

Finally, teachers also recommended that young children receive more therapy at a very early age, prior to starting school.

> *There [at the clinic] they must start with delivering some kind of service to the parents, otherwise how will we inform the parents and how will we educate the parents. We can't wait for the school. The school doesn't have those contacts to trace these children.*

Early intervention prior to school, including both direct and indirect support, is essential for successful learning to take place when learners reach school-going age. Teachers need the support of the broader school system for this to take place.

However, teachers need a good understanding of when direct support is appropriate. They need to recognise the shift that is taking place in the roles of therapists to one of increasing indirect support for the teachers and others. This change in role has implications for the relationship between the teachers and therapists which is highlighted in Section 6.2.10.

In summary, in Section 6.2.4 teachers indicate that they are concerned about their increasing workload, in part because of additional responsibilities therapists have given them. They complain about having less time to teach. They do not understand the health

promoting roles of the therapists and want therapists to give more direct support to learners including an increase in early intervention prior to admission to school. This indicates that teachers need to be made aware of the new roles for teachers and therapists in inclusive education. It highlights the need for a strong partnership between teachers and therapists.

6.2.5 Teachers need support to make changes to the school system

Teachers spoke about the effort they put into developing their own schools. Many spent long hours at the school, including staying after school and weekends.

> *And we all have families. Now you must neglect your family over the weekend because you have other duties at the school for kids that aren't even yours.*

At all the schools teachers organized open days for the parents to interact with them. They organised sporting activities and other activities such as dancing. At one of the schools they had organised a workshop for the parents on HIV/AIDS and the school policy related to it. Teachers expressed feeling well prepared to develop policy in the school as a result of courses and workshops they had attended.

6.2.5.1 Teachers need support to accept policy changes

Many teachers were unhappy with the changes in education policy. They expressed resentment towards the Education Department for the changes that have happened with the move to an inclusive education system. Teachers in one special school asked me to convey their sentiments to the Education Department:

> *If they mainstream, they are dooming another community … You should play this tape to Kader Asmal [Minister of Education at the time]!*

Some teachers saw inclusive education as having a negative effect on learners and being an inferior system to the education previously provided to white learners, which they now wanted for all learners:

With this new system, you are definitely sending out more poorly equipped children than you did with the old system.

They felt that the learners would not cope without all the facilities available in the special schools:

Now suddenly put him [a Deaf learner] in a normal school without any of those facilities … the child will be completely bewildered.

Other teachers wanted the special classes that had previously been in their school back again:

Now you have to accommodate him or her in an ordinary school … It would have been a lot easier if we still had our four or five special classes like we used to.

And I still maintain that the policy of putting these kids in normal classes is not the right thing to do. Their [the government's] way of looking at it is completely wrong.

Some teachers remarked that inclusive education was disadvantaging black learners:

If you look at your predominantly white schools, they have a school for every single disability. Now that the rest of us also want a slice of that pie… suddenly everything has to be mainstreamed.

The only real advantage that those kids have got now is to be able to say that they are no longer in the special class.

The teachers acknowledged that there was a stigma associated with the special classes:

[There is] the stigma of going from a normal class to a special class, but they get over all that within a month. But now [in the ordinary class], for the rest of his time at school … he's stranded.

[In the special class] they undergo a complete metamorphosis. It's a positive metamorphosis. Whereas in the mainstream, they are shunned and get pushed to one side.

The teachers felt that the special unit had a far more positive effect on the learners than the ordinary classroom:

> *They can be stars here … their self-esteem and self-worth also improve a lot.*
>
> *They only get compliments and are being told all the time how well they are doing.*

There was anger at the continuation of the two separate special schools for Deaf learners in one town, one previously for white learners and one for black learners. The teachers were concerned about inequity and said that the one school had many resources while the other, with fewer resources, had most of the learners with hearing difficulties:

> *If you look at our sister school at the other side of town, they have about one third of the kids that we've got and yet they have two or three speech therapists. It's simply because they are on the other side of town … But you know, they've got the money and we've got the kids.*

Changes in the organization of schools had led to fewer teachers with larger classes at some schools:

> *When we still had smaller classes, I could pay more attention to each individual child.*

One ordinary school had tried to solve this problem by employing teacher assistants with funds raised from local business. Teachers suggested that, at least in Grade 1, the classes should be smaller as this was when the foundations of learning need to be laid:

> *I think Grade 1 is where you get your basic grounding. If only those early classes could be smaller … Yes, there are many disabilities amongst the kids that we can't deal with. [The classes] are just too big. You can't give them all your attention every single day. You can feel happy if you have managed to give half the class your full attention for that day.*

Teachers found it a problem that learners were only allowed to repeat once in a Phase.

This indicates that many teachers had negative views on the implementation of the new policy. While some schools, for racist reasons, were favoured and better resourced in the past, teachers suggested this discrimination had continued in a different form. Others said learners were struggling more than in the past as a result of the closing of special classes; the change in the number of learners per class; and the restriction on how often a learner could repeat a grade. This indicates that many teachers and schools need support in order to help the teachers accept and support policy changes.

6.2.5.2 Teachers need support to facilitate their involvement in assessment for admission

Teachers were unhappy with procedure for admission into special schools. Teachers at the special schools resented being excluded from the assessment of learners for admission while the therapists played a major role in it. Teachers at an ordinary school spoke of the long process involved in having learners assessed only to find the special schools full, so the learners needed to continue at the ordinary school:

> *You know, these things also happen through many channels. I mean, we have recommended kids in the past already. But then it has to go through the department and it's a whole business you know.*

Teachers at a special school formerly for coloured learners were upset that doctors and social worker referred learners to the special school which was formerly for white learners:

> *That social worker will send all the kids with hearing problems to the white school. She's like been conditioned to do that.*

This indicates a need to recognise teachers' wish to be included in the process of assessing learners for admission, and for teachers to be given support in this process.

In summary, in Section 6.2.5 teachers described their commitment to developing their schools. However, the teachers were very unhappy about aspects of the school system affected by policy changes. There is a need for support for teachers to enable them to

understand and accept the new policies; and to understand their new roles in the process of assessing learners for admission to special schools.

6.2.6 Teachers need support to develop relationships with parents

Teachers discussed the teachers' relationships with the parents; their views of the parents' relationships with their children; and their views of the therapists' relationships with the parents.

6.2.6.1 Teacher-parent relationship

Teachers had far less contact with parents than they would have liked:

> *Very little contact. They [the parents] are spread so widely.*

At some special schools many of the learners were boarders and parents never came to the school so teachers might never meet the parents. Even at ordinary schools there were many learners who did not live near the schools, particularly those who came from the nearby farms. Their parents seldom came to the schools and frequently moved from farm to farm to do occasional or seasonal work.

> *Half of the pupils come from outside of town.*

Occasionally the teachers received notes from the parents, but they spoke of the difficulty with making contact with parents, for example to get permission for the learner to stay late after school for extra lessons:

> *He can stay after school, but then you must get permission from the parents and they [the parents] don't always show up.*

Teachers indicated that, if they had time, they would like to have been able to visit parents.

> *If only we had more time for visiting the parents at home. It's the little things that should be taught at home that we sometimes have to teach at school, like just*

comb your hair in the mornings before you leave the house. Clean your nails. I'm talking about big children now. It's like Grade Seven and so on.

You get some really good parents there, but you also get parents who aren't interested at all. They never come to the school. They never ask for the child's results.

The teachers mentioned that there were some interested parents who attended open days or parents' evening meetings regularly and were interested in the school governing body. However, the teachers said that the parents who they particularly wanted to see did not attend.

The school creates enough opportunity for the parents to get to the school because we have an open day for parents every term.

Let's put it like this: It's the parents you don't want to have around who come to the school all the time!

Those who do turn up are the ones that you don't want to see! And the one that you do want to get hold of, he doesn't show up.

We usually have a parents' day and then we invite all the parents of that grade to come. But sometimes the child with a problem, the parents never came.

Teachers at one school described their disappointment when they organized a special activity for the parents, getting a guest in to talk about crime, but very few parents attended:

We create opportunities. The parents don't want to acknowledge it though.

If only one parent were to come and say thank you. We don't expect to be praised all the time, but it would be nice if our efforts were recognised now and again.

Teachers also felt some parents did not show respect for the teachers and this was copied by the learners:

What is also becoming a problem is the disrespect nowadays for the teachers. And then it's also the parents. If a child has been absent for three days, we'll

send out a warning letter. I mean the parents take no notice. The child hears how the parents talk at home and that has an impact on him.

This indicates that teachers need support to make contact with the parents, in particular with parents of learners who are experiencing difficulties.

6.2.6.2 Teachers concerns about the parents' relationship with their children

Some teachers implied that there were parents who had a poor relationship with their children saying that parents of children attending special schools wanted to leave all the responsibility to the school. At one school the teachers mentioned that some parents were not at home when the drivers took children from the hostel home for the school holidays. The drivers had to leave the children at the local police station:

It has happened that the kids were sent home and then the parents weren't even there to collect them!

There were parents of children with disabilities who did not send their children to school till they were much older than the school going age of seven years. Teachers suggested this might have been the result of the parent's negative attitude towards their child's disability:

I've heard of a case where the parents sent a Deaf child to school when he was already ten years of age. I mean, how far is that child behind!

A teacher at one ordinary school spoke of how there were parents who found it difficult to accept that their child had a difficulty with learning:

It's not easy for any teacher to move on if the mother doesn't want to accept that there is something wrong with her child and she is not coping. She is a very slow learner.

Teachers suggested that some parents did not seem to be communicating with their children in the home, making it difficult for the child to learn to speak well:

> *[There is a problem with the] sounds that the child hear from mother and father. Or there is no talking at all at home. Dad gets home from work very tired and goes to bed early. Mum and kids sit in front of the TV. He's not communicating but he's just watching.*

The role of parents in the development of reading was considered inadequate:

> *You can also take it back to the parents at home because they don't encourage their children to read nowadays. And although we do have the reading programme at school, it's only a drop in the ocean.*

Only a few parents were encouraging reading:

> *There are a few in my class where the mother makes sure that they take out their books.*

Many children were watching large amounts of television with minimal guidance and doing no reading at home. Other parents or grandparents were blamed for "*spoiling their child*" resulting in their child having poor fine motor skills and being unable to dress independently:

> *I think a lot of them are being spoiled at home and that is why they can't do these things for themselves. The grandparents spoil them so much that they end up being unable to do anything for themselves.*

The attitude of the teachers towards the parents that emerges in these data is negative. This highlights the need for opportunities to develop the teacher-parent relationship to be facilitated by the school organisation.

6.2.6.3 Therapist-parent relationship

Although some teachers commended the therapists for their work with parents, other teachers felt that therapists should be more in touch with the parents, particularly parents who did not visit the school. They felt the therapists could help the parents accept their child's disability. They said parents needed more information on disability, and perhaps more clubs or support groups.

> *They should try [to make contact with the parents]. I think they will be able to help in some way. They have the time for that. We as teachers are busy all day with our classes. They are in their offices and they do have telephones.*

This indicates that teachers felt it was important for therapists to have a good relationship with the parents and that this could facilitate the relationship between the teachers and the parents.

In summary, in Section 6.2.6 teachers indicated that they wanted more contact with the parents. They felt that some parents do not give their disabled children appropriate support. They suggested that the therapists could play a role in facilitating the relationship between the teachers and the parents.

6.2.7 Teachers need support where learners experience major socio-economic challenges

This section presents data on the teachers' experiences of barriers to learning and teaching resulting from socio-economic challenges. Teachers spoke of the impact of poverty on the parents and learners. Many learners attending the schools were from socio-economically disadvantaged communities with high levels of unemployment. Teachers spoke of how deprivation in the community had a negative effect on the learners:

> *So there are also children who will push you just so that you will notice them. And if you look down into the problem, you find it's a poverty problem.*

> *The cooperation with the parents isn't so hot, but one also has to look at the community and the circumstances.*

Unemployment amongst parents was common and, in the Rural EMDC, many parents were seasonal worker on farms. This had a negative effect on the learners' ability to attend one school on a regular basis as the families were frequently on the move:

It's a seasonal thing. There's also a tendency for people to move away and then they return in October.

Many parents were very poor and experienced difficulties with paying the school fees. Where their child was boarding they had the additional expenses of transport, clothing and toiletries:

Financially it's also difficult for them. It's clothes and toiletries and all of that. It all adds up you know.

Some parents could not pay the daily school bus transport charge for learners living more than 5km from school, or additional charges made by the school, for example for computer facilities, putting an extra financial burden on the school and which the teachers viewed as parents not taking responsibility. The home circumstances had an impact on the learner:

I visited his home. I then discovered there was something wrong because the parents were always fighting. So the problem was at home.

Other social problems mentioned included the difficulty with many parents being illiterate or having low levels of literacy. This affected their children's ability to read and parents' ability to communicate with their Deaf children:

Language is a very big problem. I mean the Sign Language.

Our parents are illiterate, and the children don't get that stimulation at home. When they get here everything is strange to them. It's like a new world that they're in.

Although the teacher and therapists sent school reports to the parents, the teachers doubted whether the parents would be able to read them:

The parents can't even read. We send out these reports but we are not a hundred percent sure if the parents understand them.

Even if parents were able to read, teachers felt the parents would not be able to understand much of the terminology used in the therapists' reports:

> *The parents don't understand those terms being used in the report. They don't know what … muscle coordination and perceptual development mean.*

Facilities in the communities were poor with little for the learners to do for entertainment while out of school:

> *There are also no facilities for the kids. There's no entertainment. There are no shopping malls. I mean here's nothing. So it's a breeding ground for crime and violence.*

In many communities where unemployment was high learners saw no prospect of employment as adults and had little incentive to study. Many of the girls saw pregnancy as their future:

> *I mean, why should I go to school when there's nothing for me after matric? I mean, the vast majority of the girls get the "MA degree" – they become mothers. I mean there's nothing after matric.*

The lack of good role models in the community was evident:

> *We've got one well-known guy here. He's a smuggler – and he's the children's idol!*

The use of drugs by learners was also a problem resulting from the frequent use in the community. Teachers spoke of how experimentation with drugs took place, particularly where drugs were easily available in the home and the community.

In summary, in Section 6.2.7 teachers identified their difficulties with teaching learners where there are many socio-economic problems including unemployment, illiteracy, violence, teenage pregnancy, and drug abuse in the homes and community that affect

learning and teaching. The enormity of these social problems and implications for learning cannot be addressed by the teachers alone.

6.2.8 Teachers need support to network with the community

Teachers spoke of their relationship with the community and their views of the relationship between the therapists and the community.

One of the difficulties experienced by teachers in special schools was the poor contact with the community that the school was situated in, isolating the school community from the surrounding community:

> *A few [community members] are aware, but most of them are not and don't really know what's happening inside the school … Some don't even know there's a school for the Deaf here.*

Special schools were often started by community organisations or religious organisations and they retained close links with these organisations. These organisations continued to assist them financially and with organisational skills:

> *The school was an NG church institution some time ago. As a result, the NG church, as well as other churches, have quite a large input here. They will for instance help the kids every term with toiletries and clothes … and books.*

Teachers from ordinary schools mentioned that business or organisations such as Round Table and Lions had given them financial assistance.

The teachers at a special school suggested that the therapists were in the best position to make a link with the community. They said that therapists could do more to inform the community about learners with disabilities by running educational workshops in community:

> *If they work with the social workers and the clinics, they could perhaps have sessions or speak to people in workshops. Make it short sessions so that the*

parents can attend it as well and schedule them at times convenient to everybody. That is one way of getting the community better informed about the children.

In summary, in Section 6.2.8 teachers indicated that there were some schools that received financial support from community organisations. They suggested that the therapists needed to be more involved in informing the community about learners with disabilities.

6.2.9 Teachers need support to facilitate a positive attitude to diversity

Teachers were aware of different attitudes to diversity. Many teachers had a very positive approach, for example the one teacher who said they wanted to teach learners "*to value themselves*".

And a teacher at another school stated:

Look, when it comes to accepting children, we'll never discriminate against any child if he has a disability or whatever. He will be accepted.

Learners need to adapt to children with differences.

Other teachers acknowledged the need for their own attitudes to be broadened:

We would need advice … So there is a need for changing … to accept children with disabilities.

It's still a long way to go. We would like to get there and that includes everybody. But it's just that from the beginning, there was this division. And we may talk about inclusion of children but we do have fears of getting those children because we don't have the expertise of how to handle them. They may write down the policy, but when it comes to the actual implementation, then that is not easy because we feel that we don't have that expertise. We will welcome any time a physically disabled child – but how to handle it ... and even our learners, the way they behave amongst themselves and the way they hit each other, our fear now is if a disabled somebody comes to this school, how are they going to treat them? We know that in the community and at our homes we [live] with these people. But funny enough, when it comes to the school – all schools were separated – then as a result, our learners don't mix very well behaviour-wise. That is our biggest fear … So it means we still need to be educated. Our learners need to be educated.

> *The parents need to be educated. Because it starts from home, the parents need to accept it – that we need to accept each other. It should not be only at school but at home where the parents are suppose to tell their kids that a human being is a human being irrespective of his disability, or colour, or whatever. But we still have a long way to go.*

While some teachers spoke of not wanting to "*categorise*" the learners, the question arises whether some teachers and learners have a more negative attitude to learners with intellectual disabilities than learners with other disabilities:

> *Because he [a learner with a physical disability] is intelligent, the kids have accepted him. He participates where he is able to and he's got a wonderful initiative. You could almost say he is a leader. So despite the fact that he walks a bit funny and has a crippled leg, none of the kids are put off by it. He's got a lovely personality. And as I've said, he's a leader and not a follower. So his disability as such hasn't made him an outcast.*

Some teachers felt under duress to include learners with intellectual disabilities in their classes:

> *You have to take those children.*

The teachers would prefer to have learners with intellectual disabilities in special classes:

> *[A learner would be] good in a special class but she could never be good in a normal class.*

There were teachers who said they found some "*hyperactive*" learners "*irritating*".

A teacher with a child who was HIV positive spoke of the difficulty she experienced as her attitude may have made the learner become lazy:

> *[Teachers were] sympathising too much, because he is taking advantage of the teachers. They have a soft spot for him and now he is becoming lazy.*

The attitude of some parents was criticised by teachers. There was a suggestion that therapists needed to encourage parents' acceptance of their children:

> *Parents are ashamed of him because he has a disability.*

Teachers in one school spoke of the community having many backward ideas about people with disabilities and that people with disabilities were not accepted. They criticised the broader community's attitude:

> *[There is a] tendency to mock Deaf people and push them away and to avoid them.*

The teachers indicated that they had experienced difficulty placing Deaf learners in jobs:

> *… because people don't know how to communicate with Deaf people.*

Teachers spoke of the concern that people in special classes may be "*tagged*" but in practice, in their particular town, learners who had been in special classes had been well "*accepted*" in the community and had "*thriving businesses*".

Some teachers criticised therapists who they said had a negative attitude to certain learners. Teachers mentioned that there were therapists who did not relate well to children who have "*snotty noses*" or are "*smelly*".

> *If you don't like to work with kids who have snotty noses, then go and open your own practice. Don't come and work at a school.*
>
> *[The therapists] push the kid down even more [and] push him further away and avoid him.*

In summary, in Section 6.2.9 the teachers highlight that negative attitudes to diversity may be present amongst the teachers themselves, the learners, the parents, within the community, and amongst therapists. Support will be needed to address this.

6.2.10 Teachers need a supportive relationship with therapists

In this section I present the findings on the teachers' need for a supportive relationship with the therapists. The relationship between therapists and teachers was a key underlying theme amongst teachers at the special schools. The teachers in the ordinary schools, on the other hand, had no experience of working with therapists and were keen to get support from the therapists.

The teachers in the special schools indicated that problems existed related to the power dynamics in their relationships with the therapists. There appeared to be a lot of resentment towards the therapists. Teachers spoke of how therapists gave the impression that they knew everything - that they even knew more about outcomes based education (OBE) and the curriculum than the teachers. This had an impact on the support the teachers and, indirectly, the learners received from the therapists.

> *We perhaps sound very positive now … but I am very direct and I like to call a spade a spade.*

Teachers spoke of therapists having a variety of roles in relation to them. At times the therapists were in the role of the supervisor of the teacher and at other times the therapists acted as consultants providing teachers with the information they needed. There did not, however, appear to be any time when the relationship was described as being on a more equal footing, with a partnership between the teaching and therapy professionals. Communication with the therapists frequently appeared to be poor. At times the teachers were hostile towards the therapists suggesting that the therapists did not respect their skills and knowledge. They were unhappy with the way some therapists saw themselves as experts with a superior attitude, who wanted to control some of the teaching activities, for example setting and marking tests for non-verbal learners:

> *[They are] doing the work of the teacher.*
>
> *It ends up, therapists being supervisors of teachers.*
>
> *[The therapist] takes over doing the exercise [Classroom activity].*

Some of this hostility was directed at the former apartheid system, which some teachers associated the therapists with.

> *So [the school has] two occupational therapists, one speech therapist and no physiotherapist … Now let's look a bit at the speech therapist. I've been here for 11 years and we've had a speech therapist for about the last two years … When the last lady went on pension, the then government just decided not to fill the post again. But if you look at our sister school at the other side of town, they have about one third of the kids that we've got and yet they have two or three speech therapists. It's simply because they are on the other side of town [the former white school].*

They suggested that the power dynamics were linked to racist attitudes that still persisted. The therapists would give the teachers orders:

> *Do this and don't do that! …And it goes back to the past where it was a predominantly white group. Do you know what I mean? They are a little group all on their own and you don't go and scratch around there! They are in a league of their own.*

Teachers felt excluded from various teams the therapists were involved in related to the learners. They resented the therapists being involved with the initial assessment and the decision about whether or not learners were accepted at the school, while they were not a part of this decision making process:

> *As teachers, we often tell them not to just take a kid … because they just want to take a child and dump him in a class.*

And teachers in another school said:

> *Often they place the kids incorrectly … Ja, and then you have a problem because the moment you go back to them and tell them that the kid doesn't belong there, they get very upset … Then it's another whole discussion and you have to wait all over again … It boils down to this: when they evaluate the children to be placed, they should also call upon some of the teachers for input, and we have talked about this a lot in the past already … Yes, there must also be teachers serving on that panel.*

Unlike the therapists, the teachers might not have seen the parents when the learner was initially assessed at the special school, nor did the teachers have access to the information that the therapists obtained from the parent:

> *When the child is admitted for the first time, those therapists talk to the parents … [whereas] you [the teacher] must just start from scratch with the kid and discover for yourself what's going on.*

During school, meetings that did not include the teachers took place to discuss the progress of the learners:

> *They have a session each week where they evaluate the kids. But when it's my kids, they have never given me any feedback yet. They don't tell you what conclusions they've reached … The discussion that they hold is during school hours. We could attend it after school as well. I mean the child is your first priority.*

Teachers said this left them without important information about the learners:

> *Certain information is withheld from us. Even with these teams that they put together, teachers are not included in that at all. Teachers aren't represented but we have to work with the children … So we are basically here to just do their dirty work for them.*

Teachers at the special schools did not seem keen for therapists to be involved with the governing body, which seemed a particularly touchy subject:

> *Who is in charge in the school? The therapists or the teachers?*

And in another school they remarked:

> *The governing body… Dangerous territory! … I don't know if the therapists will be able to get onto the governing body because there's already school representation. … Some of the personnel, ja.*

In spite of these strong criticisms, some teachers remarked that therapists would give help or advice when they asked for it:

> *With their help, we can give some guidance to the kids. If there's a problem, then we can go and ask them to help.*

They said the schools had formal and informal procedures in place for communicating with therapists and arranging meetings:

> *If we have a problem, then we normally have a procedure that we have to adhere to. We have to come and fill in the card of course and then a date is set to deal with the problem. Everybody who is involved with the child will attend and give their input as well. And depending on what transpires at that meeting, the child will then receive therapy accordingly.*

Additionally, teachers indicated that they found it useful when therapists provided them with a report each term on the learners.

In summary, in Section 6.2.10 teachers indicated that they needed support from therapists. However, many of the teachers at the special schools complained that they had a poor relationship with the therapists. This indicates that there is a need for a supportive relationship, in the form of a partnership, to be developed between the teachers and the therapists.

6.2.11 Teachers need training

In this section I present the findings where the teachers indicated their need for more training including information and skills.

6.2.11.1 Teachers need training in identifying barriers to learning

The teachers spoke of how they found it difficult to identify the problems that the learners were experiencing when the learners were very young:

> *The therapist may point out something that I could have overlooked. I'm not going to notice anything wrong initially. It will probably be after something like*

three months before I'll notice that something is wrong. If it's not very noticeable, you could miss it because we have to deal with such large classes. And three months is almost too late already.

6.2.11.2 Teachers need information

There were learners with disabilities in both ordinary and special schools. They included learners with physical impairments, neurological impairments, hearing impairments, speech impairments, and intellectual impairments. Some teachers, including teachers at the special schools where there were therapists, complained that they did not understand what was wrong with the learners. They wanted more information on the learners' disabilities and why they had difficulties with learning. This indicated there is a need to provide teachers with information on the disabilities of the learners they work with.

6.2.11.3 Teachers need specific teaching skills

Teachers asked for further training to cope with problems related to discipline:

But now that we are not allowed to punish the kids any more, we do have a discipline problem with some of the lively ones.

Teachers, particularly teachers in higher grades, spoke of a need for skills to help learners with reading. Teachers at one ordinary school spoke enthusiastically of a reading programme the school had been a part of where teachers from both senior and junior grades had taken part in the programme:

Let's say us senior personnel, we haven't been trained how to really teach children reading skills. I mean, they are supposed to learn how to read at a lower level. So I have often said that I don't know how to teach the kids how to read properly. But now with this new reading programme, I feel that we are better informed. We are now beginning to understand how we can help children with reading difficulties.

This indicates that teachers need further training on the acquisition of specific skills.

6.2.11.4 Teachers need training to cope with stress

Many teachers experienced stress as a result of the changes that have taken place, including having learners with diverse learning needs in a classroom with a large number of learners. In one school the teachers spoke of how much stress they were experiencing as many of the boys were "hyperactive".

> *Talking about hyperactive children, in a case where a child is pushing you – really pushing you – to lose your temper.*

The teachers complained that their personal lives were suffering because of heavy workloads and the demands from the parents and the education department:

> *Teachers are put under tremendous pressures … The parents and the department – everybody expects certain things from the teachers. Teachers are only human and can do only so much. And a lot of these things cause teachers to get home feeling exhausted in the evenings. Weekends, when you are supposed to be relaxing a little, a lot of teachers will put in extra hours to get all their work done. I mean, you don't feel like doing anything on a Saturday afternoon because you are simply exhausted.*
>
> *All these things definitely have an influence and interfere with the work of some of the teachers.*

Teachers mentioned that some support was available from the other teachers in the school and the schools' teacher support teams; however they said training and support was also needed from the EMDC.

> *We help each other like that and we learn from one another as well.*

This indicates that teachers need support, including training, for the stress many of them experience.

In summary, in Section 6.2.11 teachers recognised that they needed further training including learning more about disabilities and the development of skills to work more

effectively with learners. Inadequate training may have been a factor contributing to the high levels of stress the teachers were experiencing.

6.3 CONCLUSIONS

Chapter Seven highlights the gap between developing policy and implementing it. Regardless of socio-economic background of the communities, and the level of resources within the schools, teachers were experiencing difficulties. Education White Paper 6 identifies the need to remove curriculum and institutional barriers through effective support from the district-based support teams who are expected to help teachers to be more flexible in their teaching methods and in the assessment of learning (Department of Education, 2001). No doubt time, along with the provision of support materials, assessment instruments and examples of learning programmes, will make aspects of adapting the curriculum easier. However, the reality in schools is that many learners are struggling and if it were not against school policy would not be passing. There appears to be a gulf between the teachers and the officials in the WCED. Teachers need an enormous amount of support in fulfilling their crucial role in identifying barriers to learning; identifying the support learners need; and addressing the barriers, but district-based support teams still need to be developed.

And most crucially, this will not begin to address the major socio-economic problems within the communities. Nevertheless, even within a very poorly resourced community, schools can be health promoting. With effective leadership teachers can be inspired to work as a team and the health promoting school concept can be used to give some support to the community. Building the network between the school and the community is a key component of the health promoting school approach. Parents and families of learners are the primary link between the school and the community. Unfortunately, parents have frequently been made to feel unwelcome in schools. The very parents who teachers say they want to see most of all are the ones they seldom if ever meet. The underlying reasons for this, including the inequitable power relationship, need to be explored and addressed within the school.

The major challenge negative attitudes to diversity present to inclusive education must be addressed within the broader society. These negative attitudes to diversity may be held by learners, teachers, parents, therapists and others from the community. However, through an emphasis on the values of equity and social justice within the schools it may be possible to develop a culture of inclusion within the school, even in a poorly resourced community. It is this aspect of developing a healthy school environment that needs to be emphasised. Workshops that encourage acceptance of diversity can be organised in the school for staff and parents. This might facilitate the development of the relationships between the teachers and the parents.

Teachers are the key people in implementing change and this is acknowledged in all policy documents. However, teachers feel largely unsupported. Teachers were under a great deal of stress, with morale being low. They were working long hours, willing to spend additional time at school over weekends and running after-school programmes, but this had an impact on their personal lives. The well-being of teachers is a concern that schools using the health promoting schools framework take seriously and try to address. Although teachers had made the schools' physical environments attractive, there is a question about what the WCED has done to improve the teachers' well-being. The district-based support team will need competencies to develop the teamwork within schools, including the leadership, to enable teachers to function more effectively.

In reality there is a lot of support that teachers need that cannot be expected for therapists to provide, although therapists can give support by, for example, providing advice on the curriculum and advice on adapting the physical environment. As therapists increasingly focus on their health promoting role through indirect support, learners will receive less direct support. Teachers need to understand why this change in the balance of support is happening and how it will assist them. In-service training for teachers and members of the district-based support team is needed, whether organised by the WCED or universities. It will facilitate the growth of respect for one another and the development of a partnership which is essential for an effective relationship between teacher and

therapist. The next chapter presents the findings indicating the parents' needs for support from the therapists.

CHAPTER SEVEN

FINDINGS: PARENTS' NEEDS FOR SUPPORT FROM THERAPISTS

In this chapter I present the combined findings of the three focus groups with parents indicating the support they needed from the therapists. The purpose was to identify the gap between the current support by the therapists and what is needed by the parents. This was to meet objective two: To explore the future roles and responsibilities of therapists in terms of how they could provide support within the framework of the development of inclusive and health promoting schools. The chapter begins with a description of the parents who participated in the focus groups. The findings are presented in form of themes that emerged in the analysis.

7.1 BACKGROUND

Three focus groups were conducted with a total of 21 parents of children with disabilities. Two of the groups were with parents whose children attended a special school – one in the Urban EMDC and one in the Rural EMDC. The third group was with parents whose children had been excluded from WCED schools or training centres and who attended or had attended two day care centres that were linked to DICAG.

The first focus group, in the South Cape Metropole EMDC, had four participants including two mothers, one grandmother who was the prime caregiver as her daughter had died, and the cousin of one of the mothers. Their children, including a set of twins, had physical disabilities and had attended the special school for several years. Two of the mothers had spent time in the Eastern Cape, but returned to Cape Town to get more help for their children. All the children had access to occupational therapy, physiotherapy and speech and language therapy at the school.

The second focus group, in the South Cape Metropole EMDC, had eight participants, all mothers (including one foster mother) of children with disabilities. None of the children

had been accepted into a WCED school and were attending or had attended day care centres organised by parents and the advocacy group DICAG. Children remained at the centre throughout their school years. One mother, whose child had died the previous year, was included as she wanted to participate in the focus group discussion as she had received a lot of support from other members of the group. Her child had been excluded from a WCED school and had attended the day care centre. All their children had severe intellectual disabilities and some had multiple disabilities including cerebral palsy. Other problems children had experienced included difficulty with sleeping; crying a lot of the time; and difficulty with feeding. Few of the children had any speech or were toilet trained. One child was blind. Some children were very mobile physically and others could move very little and needed to use wheelchairs. Most of the children had received occasional physiotherapy and occupational therapy at the DICAG day care centres, either by qualified therapists or students. Their only access to speech and language therapy was at Red Cross Hospital.

There were nine participants in the third focus group which was held in the Rural EMDC. They included six mothers and three fathers. All their children (including two siblings) had profound hearing loss. They all attended, or had attended, a special school. One of the children had been in an ordinary school for part of her high school education. All the families had originally come from different parts of South Africa, including Gauteng, and had moved to the town so their children could get specialized education while staying at home. All the children had access to occupational therapy and speech and language therapy at the school. Some had had contact with therapists in preschool, prior to attending this school and some had resources to get access to private therapy. Some of the children used hearing aids, others had had cochlear implants, while others had profound hearing loss and did not use assistive devices.

7.2 THEMES INDICATING SUPPORT PARENTS[5] NEED

Parents and other primary caregivers are the most significant people in the lives of children. The provision of appropriate support to parents can make a difference to their ability to give their children opportunities for learning and development. The themes that emerged indicate the support that the parents identified they needed.

7.2.1 Parents need access to education and support for their children

Parents spoke of their children's need for access to education and to support including access to special schools; access to ordinary schools; and access to therapy.

7.2.1.1 Access to special schools

Many parents of children with an intellectual disability spoke of the difficulties they had experienced with having their child accepted at school. These parents were extremely angry and frustrated with having been sent from one special school or training centre to the next:

> *It makes you sick. Like I said to Dr W last week: "Forget about the disabled children and put them in a hall and shoot them all dead. You know why? Because you people don't care about children". It is traumatic. For four years. Every year from F, from F to H, from H to … why? Potty training.*

Parents described the emotional roller coaster ride they had experienced trying to get their children to school and the repeated rejection that occurred:

> *Carl went to B. He wasn't accepted. He went to F for three weeks. He wasn't accepted. Your hopes get raised. "Oh my child is going to school." Three weeks. Everything is finished. Here my child is sitting back home … it's terrible because you're putting the parent through a lot of trauma … rejecting that child.*

Mothers spoke of their experience of numerous *"trial periods"* at different schools. At each school there was an assessment of their child which mothers found very upsetting and felt their own input wasn't heard:

[5] All names have been changed to protect anonymity.

They only assessed Carl for half an hour and I was very upset about that because they just told me they couldn't help him.

Another mother said:

If you go for like interviews or they assess your child at a training centre then the O.T. [occupational therapist] and the doctor, and they all sitting in a group there, psychologists. It's almost like as if they have made up their mind already your child is not worth it. That is something I don't like. I hate it really because they want to decide for you what your child can do and what he can't do.

The inability of the education system to adapt and accept all learners is reflected in this mother's interpretation of assessment for admission as a process in which the child is seen as passing or failing:

… and he passed his exam just like that.

However, after a long wait for admission, a year later the psychologist phoned this mother to say the child was not after all accepted at the school.

On the other hand these parents spoke of the support they experienced when their children were in the informal day care centres.

I will let her stay there until the day they decide she must go to another place or to another school. My life is hell if she is not in a crèche.

Another mother added:

The only thing to do that I can do is let him stay by [the DICAG Day Care Centre]. It's going to help us assist him, to be able to handle him.

In addition to having an intellectual disability mothers identified difficulty with communication and toileting as two common barriers to acceptance into school. Some mothers, whose children were attending a special school in Cape Town, identified the

unreliable school transport as a barrier to accessing education as children are unable to attend school without this transport.

> *She won't be able to proceed to another class next year because of being absent.*

7.2.1.2 Access to ordinary schools

Most parents did not consider sending their children to ordinary schools because of their disabilities. However, one Deaf child attended an ordinary school for some time during her high school while her sibling, also Deaf but with better hearing, stayed on at the special school. Their mother spoke of therapists at the preschool telling her not to send her children to the special school:

> *School for the Deaf, that's the last place you want to take your child.*

However, the parents decided that their two children's different personalities enabled them to cope differently:

> *You get a Deaf child that can speak and someone that cannot speak. That is the difference, I mean. A child of one father and mother but their way of communication is so different … She came to a stage where she decided she wanted to go into the mainstream.*

They listened to the wishes of their child and she was accepted at a local school. The support she got from her mother enabled her to cope.

> *In the afternoon if Sani comes from school then I have two of these types of cassettes that I must listen to. Sometimes it is four, five hours that I must sit and listen. Then I translate it to her in Sign Language; explain to her, because she couldn't follow what the teachers were saying.*

As another parent said, the child's self-confidence was an important factor in deciding whether a Deaf child could go to an ordinary school:

The child's personality also plays a big role. He can have a strong language base he can be a well communicator but if he is not emotionally strong enough then he's not going to make it. If he is not going to be able to take the peer pressure then he is not going to make it.

Therapy also made a difference to the one learner's ability to cope in ordinary school:

Sometimes I become so frustrated. A friend of mine who is an occupation therapist will take her homework sometimes and try to make her understand by saying "Do this so, and then it is easier. Leave this stuff, ignore this stuff".

7.2.1.3 Access to therapy

Parents whose children were attending a special school for Deaf children spoke of relief at their child being in the special school, as the child had access to resources they had not previously realised were important for the child including occupational therapy and physiotherapy.

We have no idea where to go to and you aren't even aware of the fact that the child should receive occupational therapy and physiotherapy. It's essential for Deaf children, I think, because once they got here it was part of their whole curriculum. It went without saying that they had to receive both of those, and speech therapy of course which is a bit more important.

Access to therapy provided by the education department came with admission to a special school. On the other hand the children at the DICAG day care centres only had access to therapy through a community based organisation and occasionally student therapists. Sometimes young children who were outside of the WCED schooling system had access to therapy at Red Cross Hospital. However, as one mother explained, when her child passed the age of six she was told to take her child to Groote Schuur Hospital for therapy but at a cost of R30 for transport this became inaccessible.

They just told me he's over six years old and he must go to Groote Schuur Hospital, but I think it's unfair all the travelling and all that stuff. Then you must still pay nearly R30 each visit. It's frustrating.

Mothers said most children outside the formal education system had no access to therapy. However, mothers of children at the DICAG day care centres recognised that their children were better off than the children who were at home who had no support:

> *Because at the hospital they only help you to a certain stage and then from there if your child is not at a day care centre your child is just going to waste away at home. So from the physio point of view, they not putting enough in the community to help the parents of these children.*
>
> *If your child is not at a day care centre your child is out of the system. If your child is not at a school he's sitting somewhere at home and nobody comes to that child. And the child is just sitting there wasting away.*

Lack of information can also act as a barrier to accessing therapy. Parents whose children do not attend special schools do not know what therapy is available. One mother spoke of how white middle class parents had access to information on alternative and augmentative communication (AAC) that

> … *never comes down to the grassroots level where we are struggling.*

Parents of Deaf children spoke of how they had struggled to learn what the implications of being deaf would be:

> *The day you find out your child is Deaf you have no idea whatsoever what it's going to entail. The first thing you do realise is that Sign Language is a very strong option you know. It is sort of one of the main options you need to do, and now what about hearing aid. Nobody, nobody informs you of the rest. Maybe because they work with these children too often that they don't think about the rest. They sort of take it for granted and they should tell you "Look, because your child is Deaf, important things that would come up either now or later is occupational therapy, speech therapy and all these things." And those are the last things that you will think of and it's also the last things you want to talk of. Because everybody just starts concentrating on communication.*

A small number of parents had access to private therapy. Medical aid schemes covered some of the costs and parents covered others. Most parents did not have this option and those who did, found the medical aid benefits did not last for as long as they would have

liked, indicating that it is the therapists employed within education support services who must in reality support all learners.

In summary, in Section 7.2.1 parents identified that their children needed access to school, either an ordinary school or a special school. Parents, whose children had been excluded from school, were very unhappy. They found the process of trying to gain admission for their children to a special school extremely stressful. Parents, whose children attended special schools, found the access to therapy through the school extremely helpful.

7.2.2 Parents need direct support for their children

Although parents were conscious of how few therapists there were and the large number of children with disabilities who might need therapy, they spoke of their need for direct support to be provided to their children on a one-to-one basis,

> *So I said they are doing a good job … I used to go and see what they were doing with the child. They actually did good exercise. They put her in a standing frame all that kind of things.*
>
> *I know the Physio she helps my child by giving him exercises so that his legs and body doesn't get stiff … They also help him to improve his communication. And therapists organised for some children to go horse riding.*
>
> *My kids get lot of help from Physiotherapists, as they check their splints regularly and do their follow ups with hospitals.*
>
> *Her leg and arm is paralysed and her hand was tight. With physiotherapy, the ball and all that did get her to work her muscles to improve her muscle strength. And eventually it just all came right.*

Parents of Deaf children spoke about the importance of exercising the tongue for the development of speech. All their children had received speech and language therapy at the special school and additionally teachers in the preschool attached to the special school did a lot to develop the children's speech using balloons and candles. Hearing had also been encouraged:

Koos's hearing was stimulated. It makes a difference.

Early intervention by therapists had made a difference to parents who emphasized that the type of therapy and the structure of the programme needed to be flexible as the child got older and therapy needs changed.

> *They [children] work well with their speech therapist up until they start reaching the age of about 12, the beginning of the adolescence. And then they don't want to go to speech therapy and they've had it. They're sick and tired of it. And then once they move beyond that by the time they should be leaving school they're moving into the hearing world they let go of it, because now they are going to get into trouble. Then they pick up their speech therapy again and then they feel now they must do it.*

Some parents wanted home-based therapy as they had found it valuable.

Parents explained how therapists could be involved in developing life skills:

> *Life skills also. How to teach the children take a lot of time because they do not understand like normal children … and this is when occupational therapy becomes important in a child's life. Sometimes one tends to forget that a blind child has a different disability or a child sitting in a wheelchair needs specific life skills than a Deaf child does.*

A father spoke of how the occupational therapist had developed his son's ability to ride in cycling races.

> *He is the only Deaf participant … this is just to give you an idea how much the occupational therapist helped him.*

Other parents suggested that therapists needed to teach the Deaf children to follow the rules of the class including sitting still in the classroom; to develop writing skills; and help with other work in the classroom or laboratory. They wanted teachers to refer their children to therapy when they noticed a problem. They explained how difficult it was for the Deaf child to read a book because of their limited vocabulary but emphasised the

need for a good knowledge of vocabulary so their children could read and write well if they were to go to ordinary schools.

Some parents spoke of difficulties their young children had experienced with the physical contact with therapists and their fear of their child being hurt:

> *They must not do physiotherapy with her, because she does not like to be touched by them.*

> *Actually I have not been to a therapy that he attended yet. I was not present yet. I just hear by nurses, they say that he cried yesterday when they were busy with him. I think he doesn't like it because maybe he gets sore. He is very stiff, his muscles is very stiff.*

A parent emphasised the need for therapists who work with their children to have specialized training.

> *I just want to say something. You know in our lives today occupations are becoming very specialised and perhaps when it comes to these physiotherapists maybe they should make it a decision at some point who their target patients are going to be and then should decide whether or not they want to work with Deaf children or with children who have other special needs, and then make sure that they have those basics. For instance if you as a physiotherapist is interested in working with Deaf children then you should make sure that you start learning everything about Deaf communication, Deaf culture that you have a much better point of view and a much better point of their culture.*

In summary, in Section 7.2.2 parents wanted their children to have direct support from therapists as they felt it had helped their children's development. This included activities for motor development; exercises to facilitate speech and hearing; improving vocabulary of Deaf children; developing appropriate behaviour; life skills development; and the provision of assistive devices.

7.2.3 Parents need effective means of communicating with their children

Communication was a recurrent theme that emerged. The children's inability to communicate with others was a barrier parents focused on in all three focus groups including the ability to speak, to hear, and the use of Sign Language or other means of communication.

7.2.3.1 Communication: speech and hearing

Some parents whose children attended a special school said that their own ability to communicate with their children had improved since the children started school.

> *[He is] not speaking very well, but able to use gestures and uses his hands a lot to communicate and he's been able to do this ever since he started here at Special School A.*
>
> *At the moment I'm happy with Special School A because now she can communicate by means of using gestures, although she cannot speak.*
>
> *We understand each other very well and I think it is because of the help she got from these people [the therapists].*
>
> *He also gets things to do at home that make him able to tell us what he wants and how does he feel. He points at this board that he got from the therapy department when he communicates with us at home.*

All the children with severe intellectual disability who attended the DICAG day care centres had difficulty with communication. A number of the mothers spoke of how they found it difficult because the children could swear but not say other words, except occasionally words such as "*ouma*" and "*mé*" [Granny and Mom]. They felt the speech and language therapist had not done enough to aid communication. They were frustrated with how much emphasis had been put on articulation of specific words in therapy:

> *It's just you must try to get them to turn that mouth. And it's not working, man. That system is not working, man. Because really, man I feel you must pay R30 to go to the speech therapist and she spends 15 minutes with you with an "apple" and a "pear" and there you go home. It's silly, man. She didn't achieve anything.*

> *My child's money that R30 is a waste, every time I must go to the speech therapist it doesn't go a little further it just the same there where it was with the apple and the pear and I'm still not achieving but it's pushing my child's future all back. So the main problem is speech therapy. I can't explain to you what I expect from that speech therapist because she has never even given me something that I can tell her "Isn't there something else we can do?" She's very stiff, man. I don't know, maybe, we hope, maybe the stiff can change. Maybe there's a new type of a language, hand language or anything.*

This particular mother felt that no attempt was made to help the children's communication skills at the day care centres. With only one speech therapist at Red Cross Hospital, she remarked that it was not even possible for the therapist to run workshops for parents once or twice a year at the centres.

> *You know I just feel that they not with the disabled - to get us to really get our children forward. As if they just want to keep the children there at the day care centre. They must just stay there forever and ever, till they're old and grey. That's what I think.*

The use of a computer programme to assist with speech was also discussed. In addition parents spoke of how Deaf children are self conscious about how they speak:

> *In spite of the fact that she is Deaf, she really hasn't got much speech but life goes on. She wants to know if we come outside. The social aspects are important and she is always scared she speaks wrong but if she knows things like how many syllables than she continues with her talking.*
>
> *[If they can] get a good foundation and they will have enough language to have good vocabulary so they can read well and can write and then they can go into the mainstream*

This indicates the need parents have for appropriate, effective and accessible therapy for their children, and the need to be listened to by the therapists.

7.2.3.2 Sign Language

Parents, with Deaf children, spoke of the difference attending the special school made to their ability to communicate with their children because the special school taught Sign Language from the day the child entered the preschool.

> *Here they get Sign Language from the beginning. By the time they are three years old they start going to preschool. Usually they start off with Sign Language. That is the language they are being taught.*

This contrasted with the parents' earlier experience at a preschool centre in Cape Town where children were not allowed to use gestures and had to keep their hands behind their backs:

> *They tell you no Sign Language. They say they must keep their hands behind their back. That is why it was so difficult for her.*
>
> *There was no Sign Language but do you know they had to stand with their hands behind their backs because Sign Language was not allowed … She learnt absolutely nothing.*

The focus, at that early stage, had been on oral language which was particularly difficult for children with a profound hearing loss who experienced extreme frustration at not being able to communicate:

> *In my case when a child finds it extremely, extremely difficult. He used to bite himself and he used to hit his head against the floor and that is why I decided to leave [the preschool centre in Cape Town] because I could see there was nothing going on in that little mind. You are not allowed to use Sign Language you must talk, talk, talk. He doesn't hear anymore. He is too small to start lip reading and just to get communication going so his little mind can work. I couldn't understand why these people could be so narrow minded to say you have to teach your child to talk and to hear. Yes, that's fine but what works for one child doesn't work for another and for a profoundly Deaf child you have to find some other way for communication. And I think for most of us Sign Language will be great.*

One mother suggested that the difficulty Deaf children had with communication resulted in a more *"aggressive"* personality than other children:

> *I think it stems from frustration, from not being able to communicate … If they're cross they close their eyes. Then you can't communicate with them … They ignore you completely.*

The parents spoke of how children who had better hearing still misunderstood parts of the conversation and might have difficulty understanding a joke. Sign Language was important to help them follow what was happening, enabling them to socialise. Parents emphasised the importance of allowing the child to choose how to communicate:

> *There was a boy here, Brown, he was Deaf and during his high school years he decided he's Deaf. Deaf culture. He refuses to talk. He always had a voice of an interpreter and he stood on those. So he left school and got a wonderful job in Cape Town and he wasn't there for very long and he went back to the speech therapist. He said, "Please I want some hearing aids".*
>
> *Understand, you are dependent on Sign Language. And I think that the child will also at one stage become frustrated. He's getting big now.*

Parents spoke of their own difficulties communicating with their children as they were not given opportunities to learn Sign Language:

> *To come back to Sign Language. You see the thing is you must do it on your own. When we came here I didn't know anything about Sign Language. So there was a teacher and he gave us Sign Language, but it was actually advanced Sign Language, but that helped me to communicate with my child … It is very difficult for adults that have Deaf children.*

Additionally, parents wanted therapists working with Deaf children to learn Sign Language:

> *There's one thing that is most important for speech therapists working with Deaf children. If that therapist does not know Sign Language, she's not going to get anywhere because she has to explain to that child what they are about to do what she expects of him. It's very important.*
>
> *All of us up to the age of seven if not later. None of us would be able to take our child to any other speech therapist other then one who knew Sign Language. It would have been a total waste of time.*

Other parents emphasized the importance of therapists' use of body language:

> *When I was in Pretoria the speech therapist did not know Sign Language but she was a very good speech therapist and she spoke clearly. She used her body if she spoke. Yes, body language is important.*

In summary, in Section 7.2.3 findings were presented indicating parents were concerned about their children's inability to communicate with them or with others. They spoke of the children needing to develop alternative ways of communicating. The use of Sign Language by Deaf children was highlighted with the recommendation that parents and therapists also learn Sign Language.

7.2.4 Parents need specific competencies to facilitate caring for their children

Apart from the need for communication skills which is presented in Section 7.2.3, parents identified knowledge and skills that they had and needed and made suggestions on the roles of therapists in developing these.

7.2.4.1 Parents' knowledge

Learning about disability had been difficult. Some parents said the medical professionals had not been open enough about their child's disability resulting in them not understanding the implications of the disability:

> *The doctor … never actually told us "Listen here. This is wrong with Marie or that is wrong" or attach a name to the disability … and "This is what you can expect of the child".*

This parent was sent to a conference by DICAG and explained how much she had learnt, including being given a book that provided information on disability:

> *That booklet helped me a lot. That book explained all the disabilities and I think it is something that all of us that have disabled children should have.*

Another parent described how once she knew her child's diagnosis she had no idea what to do next:

> *I'm speaking for myself but I think most of us feel the same way, the day you find out your child is Deaf you have no idea whatsoever what it's going to entail.*

Parents said they did not realize what should be expected at particular stages of their child's development, particularly if it was their first child who had the disability:

> *You don't realize that they should be able to do this at that stage, especially if it is your first child, and most of us, our first child was the Deaf one.*

This indicates that although parents gain their knowledge from a variety of sources, they need therapists and other health professionals to be open about their children's disabilities and share information with them.

7.2.4.2 Parents' skills

Many parents spoke about their own skills and how much they had done to help their children's development including movement development, communication development and life skills development.

One mother had adopted a 13-year-old boy from Lentegeur Hospital. However, as she could not afford to take him to Groote Schuur for therapy she gave up her job and did the therapy herself at home. She described how he could climb out of bed after she demonstrated how to do it and how he was able to move around the house to be with her:

> *If I am in the kitchen than he will also come to the kitchen. When I'm in the kitchen than I see Sammy is also in the kitchen. If I am in the kitchen he follows. He crawls on his back. Where I am he crawls afterwards. Okay it is very slow but he does it. Something that he couldn't do in the hospital. He learnt to hold his cup. Yes, I taught him myself. He can hold his mug himself. I will tell him, Sammy you must hold your mug now and drink on your own. Things he couldn't do then he can do now.*

Parents of Deaf children spoke of the enormous amount of work they had put into developing communication skills:

[It involved] teaching [their] child every single concept, every single word … it is very intensive and a lot of hard work.

The school gives you guidelines but word for word you have to do it at home with your child. Because, like I said, the speech therapist – they have too many children to cope with.

Things that I speak to him for instance "book" then I will show him how to pronounce it. This I used to do with him myself because it is the type of training I got.

One mother described how a private speech therapist used a message book for communication with her and so she could continue at home:

We had a message book and that book went to her everyday and came back to me and then she would write very roughly, today we worked on l-l, d-d and then she would say okay we can practice that for the following few days for the muscles to become used to those sounds.

A father described how he had concentrated on developing his son's life skills because he was Deaf. He now could cope with using his own cellphone and bank account.

One mother spoke of how helpful a physiotherapist had been to her, explaining how she needed to take care of her own back:

She always used to show me how to bend because you got to first look after yourself to look after your child. And at the end of the day you're hurting yourself just by picking the child up and then you sit with a back problem.

Other parents spoke of the skills they felt they needed but did not have. Some parents had found it difficult to teach their children to become *"potty trained"* resulting in their exclusion from school. One mother spoke of a potty training programme that involved living in at Lentegeur hospital for three months, which they had tried but said they withdrew from the programme because of the emotional trauma it caused her child and the family. She wished they could have been taught how to do it at home:

Carl had never been away from home, sleeping away from us. So it disrupted our whole family pattern. Carl was so unhappy, but we tried to let him go there and see how it works.

Other mothers spoke of the need to develop skills to play and stimulate their children at home:

I'll be happy if I can get more equipment or toys that will stimulate my child at home, or if I can be showed on how to stimulate my child at home.

During school holiday my child just sits at home and does nothing. Usually we give him a pen and he writes all the time and he also has a communication board that he uses to communicate with us at home.

I would like to have more activities to do with him at home.

This indicates that although parents had many skills, there were still specific things they wanted to be taught.

7.2.4.3 Therapists' roles in developing parents' knowledge and skills

Parents gained knowledge and skills from therapists:

The very first time, the very first training that I received there [at the speech and language therapist] meant a lot to me.

However, many of the parents felt that therapists should have taught them more, by sharing their skills with the parents. They said therapists could help parents who were struggling by explaining carefully why something needed to be done:

The physiotherapist, occupational therapist and the speech therapist must also come with their training and train us as parents to know more and do more for our children. You know that is also very important.

Additionally, some parents indicated that they did not know what support the different therapists offer:

I'm not sure what the role of an occupational therapist is.

What is an occupational therapist? Who is it?

Parents were particularly concerned that the schools did not have a formal system in place to get their children integrated into the community, and that they needed to rely on their families:

> *We've got a hearing child … so the sister is always helping and the sister is communicating with her … It's not right. The hearing sister is not going to be there all the time … You need a coach at the school that teaches them these things like to go to the post office and things. I think it would be ideal.*

This indicates that parents need therapists to share their knowledge and skills with them. It was, however, striking how empowered some of the parents were, particularly those who were very involved with developing their own children's skills.

In summary, parents need to know what the roles of the occupational therapists, physiotherapists and speech and language therapists are and how they differ. Parents indicated that they needed more information about their children's disabilities and the possible effects on their children's development. Many parents indicated that they had done an enormous amount to develop their own children's skills and how this had been an empowering experience. They said that although the support from therapists had been valuable, therapists needed to continue to teach them more skills.

7.2.5 Parents need emotional support

Parents spoke of the emotional strain of having a child with a disability. Mothers with children with multiple disabilities including intellectual disabilities spoke of their ongoing emotional difficulties that, at times, therapists were able to help with.

> *I think the emotional side – that, you will just have to cope on your own. Because there was many nights, many days when I was just sitting crying and thinking why must this happen to me. Why me? Especially when the child is so difficult on that day. So I think there is no support from the physiotherapist. That is something that you have to cope on your own or get it from the church or wherever you are. Your*

support group. It was horrible. Ask them, when I got here I just used to cry. And look how peaceful she is now.

It was particularly hard for parents who felt isolated when their children were not accepted into school. However, it improved when the children started attending the DICAG day care centres and parents met other parents:

How can God give me this child? I was crying all the time. How can I have my child, my child can't do nothing like other child. I was so worried what about, but now I feel better now because I see this child now. All the parents got a disabled child and they parents just like us.

If it was not for Miss Bruinders I don't know what I would have done, because there was a time when Naeema performed so much I felt like putting her in an institution. Just the way she was and the time Miss Bruinders came it became much better. Ever since she attends crèche she is much restful now. She doesn't cry so much now.

A mother, who was widowed when her child was three months old, spoke of how she had been referred for counselling by a physiotherapist. The doctor discussed the option of the child going to an institution and the mother filled all the forms but after giving it some thought she changed her mind:

And I told her [the doctor], I said, "No ways, I'm going to cope on my own. If you can't help me I will get someone to help me". So she said "No don't worry, I'll help you". They sent people out to me, to come talk to me. So I did get help from them and that was good.

Putting a child to board in an institution was a very sad experience for some parents.

They know my husband. He is a very hard person. But let me tell you, that day when we left her [her child] there, he [her husband] was crying, really. He was crying, crying …

Parents spoke of how worried they were about who would look after their children when they died:

> *My prayer is "The Lord must take Carl away before he takes me", because what would happen to my child when I die … because you find there's nobody to look after your child the way you could.*

There were parents who spoke of how some therapists had been very emotionally supportive:

> *I needed that moment just to speak to somebody and to let out. It is very important to let out, you know and to just get rid of the frustrations.*

In addition, the experience of being a part of a parent support group was valuable for many parents, including being reassured by meeting other parents with children with disabilities:

> *The child can't do nothing like other child. I was so worried … but now I feel better … All the parents got a disabled child and they're parents just like us … We as parents support each other.*

There were, nevertheless, people who were positive about the experience of disability. A mother spoke of how the boy she adopted had been a joy for all:

> *I'm the foster mother of Sammy. Sammy, I met in 2001. I met him at Lentegeur Hospital. I was working there so I met Sammy there and I fall in love with him the first day I saw him and he fell in love with me the first day he saw me. So it was love at first sight. He's a lovely child. I don't know what's going to happen the day when Sammy must pass away because he is the joy in the house. Everybody loves him in the road. Everybody is madly in love with Sammy.*

In summary, in Section 7.2.5 parents whose children had not been accepted into school described the emotional strain imposed by having a child with a disability. They indicated that this was worse before they met other parents with children with disabilities and met up with parent support groups. They indicated that they needed emotional support from therapists and others in the community.

7.2.6 Parents need advocates to work with them in support of their children

Parents indicated the need for support in advocating for the inclusion of all children into schools and for changes in attitude towards children with disabilities in the community.

> *So people can understand the disability and so people can understand our children. It's all about breaking those barriers, you know. I think if people understand more about disability they will react different, you know.*

They spoke of their own role as the advocate for their child when their child was experiencing a problem.

> *I was simply speaking on things that was not right for Carl. Your child's right also. Carl doesn't speak and if Carl is unhappy who must speak for him?*

A mother spoke of how she had explained her foster child's disability to the neighbourhood children. Initially they teased him but later they started to include him in their activities:

> *When I brought Sammy home the first time the children used to stare and make fun of him. I used to go to them and explain that he was born like that. Even though he is not my own child they shouldn't make fun of him because it could happen to anyone. Now they accept him like he is and if they do not see him for a few days, they will come knock and ask about him. They ask "We didn't see Sammy". They will then bring him something – a lollipop or a packet of chips. Or they will knock and ask where he is because he is always outside. When the children play outside Sammy wants to be outside all the time; he doesn't like being inside.*

Another mother spoke of how some parents did not allow their children to spend time outside the house:

> *Let the child go outside. Let he or she move. Let them be outside irrespective of how the people are. They will get used to the child.*

However, one mother described how she needed to keep her teenage son inside unless she was outside with him because of the risk of sexual abuse:

> *I'm protecting my child from danger and I'm also protecting my child from being sexually abused because I know that happens in the community.*

This mother spoke of how she felt responsible to include him in social activities:

> *I take him out. He goes to the beach. He goes everywhere but still we go alongside with him. But if the community would change and people were seeing things different, we wouldn't have had to go to that extent.*

Some parents spoke of how speaking up for their child had led to difficulty and the child or parent feeling discriminated against:

> *If you are a quiet mother they will mess you around but if you are somebody that voices your opinion then you get targeted or your child get targeted … That is what's happening in our community. It happened to me also.*

There was a strong feeling that attitudes in the community needed to change. The parents suggested this could start by advocating for a change in attitudes at school level. They suggested that therapists could become involved:

> *I think it's very important that [therapists] keep awareness campaign of the schools ... I think people should get into the mainstream school and educate the people.*
>
> *And you must fight for everything, so who's gonna now fight for that child. Is somebody else gonna have that strength to do it, you know. So we just want you people to know how important a physiotherapist is in the life of a mother and of a disabled child.*

Inclusion into the community was seen as most important.

> *To isolate a Deaf child is not good at all. So I just want to say where therapists come in, is to introduce Deaf children to normal children.*

Parents had experienced some successful advocacy campaigns. Parents at one school spoke of how the police had sent someone from the police force for training to learn Sign Language to be able to communicate with Deaf people as a result of their advocacy work.

In summary, in Section 7.2.6 parents reported on the need for advocacy to change the negative attitudes of people in the community and enable their children to be accepted as a part of the community. They suggested that therapists needed to become involved with the parents in the advocacy campaigns. They mentioned some successful advocacy campaigns.

7.2.7 Parents need a supportive community

Parents described difficulties with inaccessible environments and negative attitudes.

7.2.7.1 Accessible supportive environment

The physical environment presented barriers to the inclusion of some of the children. In one town with a number of special schools, parents spoke of the construction of a new shopping centre which had not taken the needs of people with disabilities into consideration.

> *You know Worcester is actually the town for blind or Deaf … and they all said they forgot and they didn't think about that.*

Other mothers of children with physical disabilities in wheelchairs said they were living in a poorer community complained where the pavements and the roads were in a very poor condition making it difficult to push the wheelchair around the neighbourhood. As a consequence the children could not interact easily with other members of the community including other children.

> *Our place is not structured so that children can be part of society.*

This indicates that parents need support in addressing the inaccessible physical environment of the community.

7.2.7.2 Need to facilitate positive attitudes of parents

Parents acknowledged that their own attitudes to their children's disabilities could also be a barrier to their children's development as it led to the parents being over protective.

> *I also have an attitude where my child is concerned. Maybe change my attitude also. But because of a lot of barriers that has been put up my attitude also needs to change. But how can my attitude change if things isn't adaptable. It tough, it's really tough; sometimes you feel like the barrier is off and then at times it's on again … you've been like you're protecting him you know like a mother hen standing there. You have to have that role. Because of the child you'll have to.*

And another parent spoke of how she stopped her child from doing certain things that other children of the same age would be doing.

> *I don't allow him to do certain things because I think he is not capable and I'm afraid that he might not do it right or he will hurt himself or whatever. I made many mistakes not allowing my child to do enough by himself, because I was overprotective and still am because you think he's not capable of doing that and that also breaks down his confidence and whatever goes along with it. Because you're overprotective, why your daughter of five, she can use the microwave oven, but Eddie only started making coffee for himself a year ago and he was ten. If being a mother is being overprotective then you're not helping your child.*

One father spoke of how he had initially been protective but later gave his Deaf son opportunities as he wanted him to be independent.

> *I could be very overprotective … I just felt that we don't have other children and the day something happens to us than he will be alone in life. You know I even taught him to drive*

A parent emphasized the need for the family unit to remain intact even though the child with the disability was inclined to feel different.

> *A big part of it is that your family should stick together like any other normal one would and you must at all times try to prevent a Deaf child from feeling different. I have a picture of my son that he drew I'm having it framed right now, where he drew the family. I think he did that last year when he was in grade 2. His father is*

a nice big figure, his mother a little bit smaller and his sister. And he is here in this corner. And everybody's clothes look exactly the same, like a chequered pattern. The whole family is there and he stands on this side and his clothes are directly the opposite to the rest. So now I tell you everybody has a smiley face so he's happy but he is very much aware that he's not part of the family circle. He's different and he's standing on the sideline. You shouldn't neglect the normal children who have Deaf brothers or sisters. The normal children should be included at all times. I don't know how it should be done. Maybe to have a group session because they do play an important role.

This indicates that parents need support to maintain positive attitudes to having children with disabilities.

7.2.7.3 Need to facilitate positive attitudes in the community

A mother spoke of how the people in her community excluded children with disabilities:

About the problems we get from community, I hardly report it at the school, because most of the people in our community don't understand disabled children because sometimes, when these kids play with other kids in the community they become aggressive and fight with them.

But another mother, in another focus group, described a different experience with her child being included in the community:

My child is being loved by other kids in the community. They even take her for walks.

Another mother said it was the adults, not the children, in the community who excluded their children:

Our kids are being loved by other kids in the community more than by adults. Most of the adults have problems with disabled kids. You ask a favour from a neighbour to look after your child. They always tell you stories, thinking that your child is a burden.

The attitude of the hearing community to people in the Deaf community was seen as unfriendly.

They don't understand each other. We would like to see the outside community get more involved.

There is a need for business to provide appropriate training for employees so they can communicate with all customers. We've been talking about our Deaf children not being able to go to the bank and fill out all those forms: you would think that the bank would go through the trouble and take one person for a Sign Language course to be able to help the Deaf community. They don't. It's unbelievable.

The parents spoke of their children becoming more self-conscious about wearing a hearing aid as they got older.

He refuses to wear a hearing aid because the people will see he is Deaf. He is at that stage now where he is very self-conscious.

This indicates that parents need support to cope with the negative attitudes in the community towards children with disabilities.

7.2.7.4 Need to facilitate positive attitudes in the schools/institutions

Parents also spoke of difficulties children had experienced at the special centres/training institutions they had been at, resulting in the parents withdrawing them from the centres.

Let's just say he was very very unhappy. He was a child that was potty trained and all of a sudden he started weeing in his pants and he cried a lot. Myself and my husband decided we need to keep him home. He came home one day with a big blow on his head. He came with his whole elbow dislocated … and every time I will go to the teacher to speak to her she would say: "There's 20 children in the class, I can't have a one to one attention with Carl".

Later these parents put their child in a DICAG day care centre where he was happy for a few years.

Then he went to a bigger class; I think there he was physically bullied. You know how children are, they bully one another. Then just terrible things happened to Carl. So I said no, my child is very unhappy, let me take him out. So that is the reason why he's not at school and he's at home.

A grandmother spoke of her grandchild's experience at a special school:

> *Something me and her mother we didn't like about Special School A. We stopped her from attending the school on that same year… My grandchild accidentally wet and messed herself. Instead of cleaning her they put a plastic bag on top of the mess. I still feel that was unacceptable for the staff of Special School A to do that.*

This indicates that parents need support to address negative attitudes to their children within the school.

In summary, in Section 7.2.7 parents indicated that the physical environment in their communities was often inaccessible. They identified the need for support to so they could develop a positive attitude to their own child's differences. The negative attitudes of people in the schools and in the community act as barriers to their children participating in society.

7.2.8 Parents need a supportive relationship with therapists

In this section I present the findings from parents about their relationships with therapists. Parents spoke about some very positive experiences in their relationships with therapists and some very negative ones.

One mother spoke of a therapist who was *"wonderful"*, who helped open the parent's eyes to the world of the Deaf person. Other parents mentioned that the therapists were always helpful:

> *[They are willing] to give help when needed and give advice.*

Some spoke of how they kept parents informed, letting them know when their child was doing well or struggling with something:

> *He can kick a ball and can walk on a line but he doesn't have the self-assurance to climb on a ladder perhaps.*

These sort of things, they really keep you up to date. I think with all kids you don't think of these things.

Another parent spoke of the good relationship she had developed with a speech and language therapist. As a working mother she found it hard to find time in the day to communicate with the therapist but she was able to phone her at home in the evening:

We had this message book … and once every term, when she had discussed the whole thing in detail. So I had a very good relationship with our speech therapist and we had good contact but even that could be much better. And I think I was in a much better position than most other parents.

Other parents spoke of how they went to see the therapist at school to discuss their child with her. One parent spoke of going to meet the whole team.

Earlier when our children were much younger we used to have sessions with the principal, teachers, therapists, occupational therapists, the psychologists, to discuss the child.

Parents really appreciated home visits, which a therapist employed by community based organisation working in their communities had done.

The occupational therapist Klara used to visit her at home when she was sick.

Other parents commented that home visits needed to be started again as it was an important way for therapists to find out what was happening in the community.

My wish is that, they must do home visits, so that they know what is happening in our communities and it is true that they used to visit our homes and organization like SACLA [a community based organisation] were very helpful.

One mother spoke of the emotional support she received from an occupational therapist who made herself available for the mother day and night while she was going through a crisis period.

> *There was times I wanted to strangle Carl because he's too hyperactive. You just get to that point where you can't take it anymore. And then she always used to said to me: "Whenever you need me, whenever you feel frustrated, whenever you need to pick up the phone" … I phoned her one night quarter to two in the morning and I mean she was really, really available for me. I'm not saying that, this is not a criterion that I'm setting that you could phone a therapist or occupational therapist three o'clock or two o'clock in the night. I'm just saying the extra mile that woman went for me as a parent.*

Other parents had negative experiences with therapists. One mother spoke of how her speech and language therapist had not explained things to her as the physiotherapist had done:

> *I don't understand the speech therapist, I don't understand her part in my child's life because she's just so doff as what I am … It's almost as if she hasn't got the pluck to teach or to work with you as the mother. Now she says: "Adam this is a apple, isn't it? And this is a pear, isn't it?" And now Ms Julies you must say a-p-p-l-e, p-e-a-r, alright, now you must say apple, pear. What I want to know is, is there no, someway man, like you sit with your physiotherapist and she'll tell you why I'm doing this weight-bearing, why I'm doing that, for his back or hip. But all she's interested in is that apple and that pear and now you must turn your mouth to that apple and that pear.*

Another parent spoke of her communication difficulty with a therapist.

> *There is very seldom a link. Communication is a big problem. It's really a big problem.*

The parent expressed the need for parents and therapists to be able to give the same instructions to the children, reinforcing and not contradicting each other.

> *I think there should be an interconnection with the parents as well. Telling them what they're doing, explaining how they're doing so parents can also be active with their son. To form a structure and so that the child knows the therapist is not saying one thing and the parent is saying another. Then you just confuse the child. The most important thing maybe is the contact between the therapist and the parent so that the therapist can say: "Look this is what I am busy with. This is what you can practice at home before I see him again".*

One mother said how she wanted the physiotherapist to become closely involved with the family. She didn't want to sit on the sideline while her child had therapy.

> *Get us involved. You become part of our family. That's what we expect from a physiotherapist … I should feel free to phone any physiotherapist because you will understand how we feel and how we feel protective over the children.*

Parents were concerned about therapists or student therapists who they said did not seem to treat all children equally and were choosy about which child they treated.

> *They say "No that child has a runny nose".*
>
> *I'm rather gonna go for that pretty child and leave that black child or the child has bushy hair. No you must be versatile. If you come in there, the first child that is there you must take the child and love that child because that is my profession; I picked that profession so I must put away colour barrier.*

A mother spoke about how *"the physiotherapists get very angry with me"* for not doing things for her child she had been asked to do. This mother spoke of how it could be difficult to explain her reasons to someone from a different background:

> *… because most of these therapists come from different backgrounds to ours it becomes difficult to tell them about these things. It is not that I'm saying that they are not doing their work. They are always willing to help and listen to our problems.*

Parents spoke of how they were unemployed,

> *from less privileged communities … [and the children] less stimulated*

because they could not afford the equipment and things that therapists used and that they saw on television.

In summary, in Section 7.2.8 parents described how some of them had experienced a positive relationship with the therapists, including a therapist who opened the parent's eyes to the world of the Deaf, but other parents had negative experiences. The parents

indicated that they needed therapists to include them in the treatment; for all the children to be given equal access to treatment; home visits; emotional support; and effective communication. Some parents reported difficulties communicating with therapists coming from different cultural backgrounds from themselves. This indicates the need parents have for a positive partnership with the therapists.

7.3 CONCLUSIONS

In spite of South Africa's human rights based constitution and policies supporting inclusive education many children do not have access to education. Overcoming physical barriers, including inadequate transport to special schools for learners with disabilities as identified by parents, is needed. However, developing an "ethos of inclusiveness" as described by the Department of Education (Department of Education, 2003c: 8), which is envisioned for full service schools, is even more important. This whole school development, incorporating the health promoting school approach, is described as a school where diversity is celebrated in both policies and practices and where all learners, school personnel and parents are valued.

Improved collaboration between the Departments of Education and Health is needed to ensure children have access to support, including therapy. To a great extent access to therapy has been determined by admission to a special school, particularly special schools that charge higher fees to enable them to employ additional therapists in school governing body posts; ability to pay for private therapy; and residing in a wealthier urban area. This inequity needs to be addressed urgently by the Department of Education through funding of additional posts in poorly resourced urban and rural areas. The employment of therapists in community service posts, as done by the Department of Health, might be one solution, though the newly qualified therapists' lack of experience might require intensive in-service training.

Many barriers related to communication were identified by parents. Access to speech and language therapists outside the special schools was very limited and transport was costly.

Parents described the therapy outside the special schools as inappropriate and said they were not taught alternative methods for communicating with their children. Sign Language is considered the 12th official language in South Africa but it is only taught at a small number of special schools. It can open up the world to the Deaf child, and opportunities for parents of Deaf children to learn Sign Language need to be made from very early on in their children's lives. Collaboration between the Departments of Health and Education around this is needed. The acquisition of knowledge and the development of skills can facilitate empowerment, for example, the empowerment of learners, parents, school staff and therapists. This skills development is a key component of the health promoting schools framework which emphasises the development of the personal skills of all in the school community.

Although there are times when most parents of children with disabilities need emotional support, it becomes a far greater need if they are living in a community where prejudice and discrimination is rife. Schools that strive towards developing a culture of respect and that promote the values of equity and justice are health promoting will have an impact on the neighbouring community through the families involved with the schools. Parents will gain emotional support through the social networks that develop, while building the social capital within the school and local community, such as in the development of parent support groups. There needs to be increasing emphasis on a partnership between parents and the school. Therapists and others from the district-based support team can, in partnership with the parents and organisations of people with disabilities, act as advocates for inclusion in social activities. Discriminatory attitudes need to be challenged at all levels of society. In line with the health promoting schools framework, this starts with ensuring that there are policies that support inclusion in place at the school level.

Parents indicated that direct support for the children was valuable for their children's development. This included exercises; speech training; and the stimulation of their hearing. However, the importance of indirect support was also emphasised. Parents acknowledged the support therapists gave through the provision of assistive devices and recommended that therapists become increasingly involved in life skills training which

needs to be integrated into the curriculum. Parents indicated that they need more information about their children's disabilities and information on what support different therapists can give. They wanted therapists to continue to share their skills with them, in particular the development of movement, communication and life skills.

Parents spoke of the importance of their relationships with therapists. They described positive and negative experiences they had had with therapists. Parents identified the need for therapists to involve them when treating their children; for all children to be given equal access to therapy; for therapists to do home visits; for therapists to give them emotional support; to be understanding of the parents' cultural background; and in particular the need for effective communication between the therapists and the parents.

This chapter highlights the challenges for therapists to reorient their approach to providing support to a health promotive model of support in particular in developing their skills to act as advocates to ensure children have access to therapy, including direct support, and to give support to parents, especially emotional support. Using the medical model and only focusing on the child's impairment or disability does not give the parents the support they need. Therapists could provide holistic support to parents by using the health promoting schools framework which would include both direct and indirect support. This needs to be done as a part of the district-based support team, but also in collaboration with the health sector.

The next chapter presents the findings from the participatory research with the therapists that led to the therapists identifying the competencies they require to provide appropriate support.

CHAPTER EIGHT

FINDINGS: ROLES AND COMPETENCIES OF THE THERAPISTS

In this chapter I present the findings from the participatory action research with the therapists which was described in Chapter Four, Section 4.2.5.1 and illustrated in Figure 4.1. The purpose was to meet objectives two and three of the research: to explore future roles and responsibilities of the therapists and how they could provide support within the framework of the development of inclusive and health promoting schools; and to identify the competencies required by therapists to identify and address barriers to learning.

8.1 IDENTIFICATION OF NEED FOR RESEARCH ON ROLE OF THERAPISTS

The first focus group I held with the therapists was at a special school in 2001. Although Education White Paper 6 (Department of Education, 2001) was only published later that year there was already a lot of talk of the need for therapists to provide support to learners in ordinary schools. Most therapists in this group had already visited ordinary schools, in an attempt to give support beyond the special school they were based in. However, they spoke of their difficulties and the need to have their roles clarified. The questions that emerged indicated the concerns the therapists had in relation to changing their roles and their ability to provide support:

- Policy:
    - How can the therapists implement policy changes?
- Ordinary schools:
    - What happens in ordinary schools?
    - What will the therapists' relationship with ordinary schools be?

    - What will the therapists' role in ordinary schools be?
    - Can therapists be orientated into ordinary schools?
    - How can therapists network with ordinary schools?
- Curriculum:
    - How can therapists find out about the curriculum so as to avoid duplication in the work done by the therapists and the teachers?
- Relationship with teachers at ordinary schools:
    - How can therapists support teachers in ordinary schools without teachers finding their work becoming more difficult?
    - How can therapists support teachers without giving them more administration?
    - How can therapists support teachers without the teachers feeling they are an imposition in the classroom and wishing they were not there?
    - How can therapists do a "needs analysis" in the schools?
- How can the "stories" or case studies of what the therapists have tried to do in ordinary schools be recorded and the information shared with other therapists?

The findings indicated that the therapists wanted to work with teachers in ordinary schools. The EMDC had given them names of ordinary schools to give support to. However, when they visited the schools they did not know what was expected of them and the teachers did not understand why they were there. The questions the therapists raised highlight the difficulties these therapists were experiencing. They demonstrate that the therapists were not at all clear about how to change their roles to support an inclusive education system. Identifying the changing roles of the therapists and the competencies they need to provide support to all learners through support for the teachers and parents, has been the purpose of my research.

The next phase of research with the therapists involved a survey to determine who was working with children and their current support roles in schools. This is described in Chapter Five.

8.2 SUPPORT NEEDS IDENTIFIED BY THERAPISTS

In 2003 focus group discussions were held as part of workshops with the therapists in the two selected EMDCs to enable the therapists to identify how they could provide support to the school system. The findings are presented in the form of themes that emerged in the analysis.

8.2.1 Therapists' support for teachers

The therapists' focus of support for teachers was around access to the curriculum.

8.2.1.1 Support for access to the curriculum

Therapists recognised that they need to ensure that the support that they provide does facilitate access to the curriculum. It must help the learners to learn more effectively. They also acknowledged that teachers do not want to have tasks to perform with the learners that are additional to the curriculum:

> *Look I'm not an occupational therapist, but the experience that I've got in terms of these programmes is that they are separated from what a teacher is supposed to do in the classroom. It's considered to be an extra, which makes implementation very difficult. Because the programme that's put there will be difficult for a teacher to handle in its entirety. And the terminology is also sometimes not known to the teachers either. So I'd say over-complication of instructions because I think occupational therapists are not trained as teachers. In other words they can't deliver the curriculum, and that is the language that the teachers are speaking. On the one hand, there's a bit of a communication gap and on the other hand, the expectation of the professional person are too high where a teacher is sitting with a class of 40 to 50 learners. They expect all the kids to follow the whole programme and that is of course not possible.*

This suggests that therapists need to understand the demands on the teachers of teaching a large class and that therapists should not be unrealistic in their expectations. It is important that therapists communicate well with the teachers to be able to gain an understanding of what is expected in the curriculum. Therapists explained how they attempted to integrate their support into the curriculum:

In the first instance, we try to integrate the stuff with the curriculum. We [ask] the teachers how it integrates. And when we apply things, then we ask the teachers and we check ourselves to see if it works or not. There are little things like [motor] control, visual guidance and how to integrate these things to say where you teachers can … you're doing it already in a sense, but we pin-point precisely where you must do it correctly so you know you are working on it indirectly.

We tell the teacher where she can actually apply it in her class [in] the curriculum, not separate after school… You must apply it and you must learn a little. And that we do a lot of. We work very well with [the teachers] and they learn from us and we learn from them. In that way we learn a lot about the curriculum and stuff. From my own experience I have found indirect support does help.

In other words, this thing is actually part of the teaching programme, or becomes part of the teaching programme … In other words, to integrate it somehow.

Therapists mentioned that they had organised skills development workshops for the teachers, for example skills to help learners [with disabilities] to dress themselves and skills to maintain wheelchairs. They had organised workshops to teach housemothers and teachers ways of assisting the children to sit:

When she sits properly she can write [but] some teachers struggle to do what therapists suggest, for example, having terrible seating positions.

They emphasised the importance for teachers to develop technological skills to assist with learning:

Educators must realise that the kids must be taught with the technology of the day. You can't stay third world.

Although therapists recognise that they need to provide the teachers with support to help learners gain access to the curriculum, support needs to be an integral part of the curriculum and not an "add-on" to it. Without the teaching skills needed to present the curriculum, therapists need to work in a partnership with the teachers for an effective outcome.

8.2.1.2 Evaluating outcomes of support

There were therapists who were unhappy that so much emphasis was being placed on educational outcomes. Some therapists wanted the outcome of the learner's therapy to be measured by changes in the learner's functional ability and not only by the learner's ability to pass the grade.

> *[Teachers] measure if a child can pass, not if they can sit. [They] need to measure the child's function.*

This highlights a difficulty therapists experience in identifying and addressing barriers to learning. While many teachers do not recognise or acknowledge the association between functional abilities, such as sitting, and the ability to achieve learning outcomes, there are also therapists who, using a medical model, only identify the impairments without consulting with the parent or teacher to determine if or how these are impacting on learning.

Therapists spoke with a sense of empathy of the enormous pressure on the teachers, who acknowledged that their methods or pace of teaching may be the barrier to learning, to change their teaching methods to ensure that the learners achieved the required curriculum outcomes:

> *A lot is expected of the teachers now also with programmes that we demand from them that a child should have … [We ask]: What problems do you have with him? So what problem have you seen? What have you done about it? What was the outcome of the problem? But … [if] the teacher can't say it was positive, that is his problem. And I think that is something that's on a teacher's mind when you approach him is exactly that: "Have I done enough? When is enough ever enough? What are the things you can actually do?" … There is a huge amount of pressure for the teacher.*

This therapist continued, saying that it would be better for teachers if they could acknowledge that some barriers to learning may be the result of factors within the learner:

> *Say to him: "But the child actually has this problem. It is not because of you, who aren't a good enough teacher. What are you doing about that problem?" It is as if*

a huge weight is removed from his shoulders because he now realises it's a problem that the child has got. "Let's look at all the different ways we can tackle this problem." Then he is no longer under so much pressure.

While essential to identify factors that lead to barriers in the broader system, the factors within the individual learner cannot be underestimated or ignored.

8.2.1.3 Teacher to teacher relationship

Therapists noted that the quality of communication between teachers varied considerably and this had an impact on the support the therapists gave the teachers. At times the teachers shared the skills they had learnt from the therapists with other teachers. However, at other times complex dynamics and poor communication between teachers affected their ability to learn from the therapists.

I have found that sometimes I will get support from one teacher, especially with the junior [teachers], and they will talk to each other. And that one teacher would do or use what I gave to her. Then another teacher will come in and they will talk about it, and in this way things get passed on. So sometimes it's not just indirect support towards one teacher, one class, but it actually circled out to these other classes through that support. A lot of teachers have a lot of contact with the mainstream and so it gets spread around. So it sometimes goes much wider.

There are teachers in the junior classes who have a huge influence on the children in their classes. They are very insistent that the children should eat correctly, but the senior personnel are more negligent. They won't persuade the kids themselves and so on. But those junior teachers are so insistent on it and they don't want the basics that they have in the junior department to go to waste, so time and again you will find that they will be talking to those senior teachers about it. They will really pressurise them to keep that skill and not for the learners to lose those skills.

But I've also noticed that there's no real communication with the teachers themselves.

The presence of strong teams of teachers with good working relationships with one another will make it easier for support that therapists provide to be used more widely in the particular schools. This has important implications for the development of inclusive

and health promoting schools where the importance of the wellbeing of the teachers and the development of social capital is recognised.

8.2.2 Relationship between therapists and teachers

Therapists identified how effective support was dependent on their relationships with the teachers. This includes various aspects highlighted below.

8.2.2.1 Asking for support

Although therapists felt that teachers needed their help, and even appeared to want to be helped, they said many teachers did not ask for help. They ignored their suggestions and turned down their offers to help.

> *They're sitting with a problem that they don't really know how to handle, but whatever you suggest, they don't want to [do it].*
>
> *Teachers don't ask why a child doesn't manage [referring to a boy with gross motor-planning perception difficulty].*
>
> *The teachers have also said that they don't want to be told. But they often complain to one another in the tea-room and to the vice-principal. But they don't come and talk to you. So they are moaning about things and even though we are there to assist them they don't ask for your help. And when you show them the number of people at the end of the year who need help and who can't read and so on and suggest a workshop to deal with some of the problems, then they say no.*

Therapists spoke of there being two types of teachers: those with whom they could work, providing indirect support; and those with whom they found it more difficult to work, who preferred a traditional approach with one-on-one therapy and fewer demands on the teacher:

> *I think it's basically one's personality. You [the teacher] want to go on and on stagnating and you don't want to develop. You do get teachers who want to [develop]. They also come and ask, and you can see when you present it they do it and they don't mind if you move into one of their classes. They enjoy observing how you can be of help. Some again say: "For this child [the therapist] told me to do this. And you know, I find that I can now do the same for all the other children who've got the same problem". Other teachers just don't want any help at all.*

They're quite happy to walk in and just do their work like they did 20 years ago, and then walk straight out again. He doesn't want to develop.

However, therapists acknowledged that while some teachers may be afraid that asking for help could be seen as a sign of weakness, other teachers do not want their roles to change:

I think a lot of them are also scared to take chances with new methods. Like she's said, 20 years ago it was working so it must be working today. Often it's also a case of them being scared: "What will other people think of me because it's such a simple thing. I should really be able to do it. So I don't want to ask for help because everyone will think that I'm incapable of doing my job". I think that is also quite a big factor.

This apparent fear of possibly being seen as ignorant highlights the tensions in the relationship between the teachers and therapists.

8.2.2.2 Sharing skills and knowledge

Therapists spoke of how the move from direct support for learners to indirect support had already begun:

Something else, you go into the classroom and you sit down and you show them [the teachers] things, exactly how and what, and the programmes. You work with them. Your work is in the class. You are talking to each other. So, ja, I can't see how we can be more indirect.

The therapists recommended that the teachers use individualised programmes with the learners that are developed jointly by the teachers and therapists. They emphasized ongoing contact with the teachers to monitor the support the teachers are giving the learners:

I have found that with the individual learner's programme, a lot of kids do get something from that. Now we have to compile an individual learner's programme and the teachers sit in on that … Afterwards you have to go and do follow-up work and keep in touch with the teacher and ask continuously whether it has worked or not … and then you can immediately see whether the teacher has worked on that kid or not when you fetch him the following week. You and the

teacher must stay in touch continuously. When you go and fetch the child from the teacher, you can immediately see whether work has been done or not.

Therapists felt that, for a successful outcome, they had to be very sensitive about the way they approached the teachers when they made suggestions about what the teachers could do with the learners:

I've also found that … and it's kind of better if it's done in an informal manner. You are just in the classroom … and it's done in a by-the-way sort of way. That will be more positive … or tea-time, that is kind of more a productive time where I could get something across in an informal way when you sit and just chat about a child.

You sometimes have to try alternative approaches because at the end of the day you want to help that child.

They're really tuned into this one-on-one therapy situation. And if you then come in and say: "Oh that is very interesting doing it like that, have you ever thought of doing it in another way?" You know you don't want to say something too directly. Let them come to the conclusion themselves that it's better to do it in a different way.

This raises the question about whether these teachers need and want support from the therapists. Who identified the teachers' or learners' need? Will the support that the therapists are giving provide the learner with increased access to the curriculum? Or are the teachers equating support from therapists with "being told what to do"?

Therapists suggested that at times teachers in ordinary schools were easier to approach and more accepting of indirect support than teachers working in special schools who were used to learners receiving direct support:

And I think the mainstream is sometimes almost more open for something like that [indirect support] because they don't work that closely with therapists. So they are sometimes easier to convince than your special schools.

They spoke of how difficult it was to expect teachers to give effective support when they, as therapists, have trained for many years to develop their skills:

> *I feel that with our training already, it's such a mass of information, and then you only have to start learning after you've got your degree … start all over again. So it's very difficult to try and indirectly support the teachers now who have got nothing of that information … And also, the way you go about training, how on earth can you get that through to the teachers. I just don't see how you can even try and expect them to get to the learner that took you so long to learn.*

Additionally, there was the suggestion that therapists needed to have experience of giving direct support to learners before they could pass on their skills to the teachers, making it difficult for a recently qualified therapists to provide indirect support:

> *I think almost to have the skill to be able to pass it on to a teacher, you need experience for that … I've seen it work.*
>
> *It worked very well with the actual physiotherapists who had one of the nursery classes. And she actually spent a lot of time in the nursery with the teacher. So I think that the teacher didn't feel that this physio came in and just gave advice and sort of led the group. She sat on that floor in the class spending time with and moving from child to child. I think then the teachers could see what she was actually doing … But even for us it's difficult to do therapy yourself when you don't get that practical hands-on experience … perhaps spend more time in the classroom and if they would allow you to start building on the relationship first. And you also ask for the teacher's advice, not always give them advice.*

Other therapists emphasised that although there were some teachers with whom they found it difficult to work, there was much they could learn from the teachers:

> *I don't think it's all teachers. Some will understand it and incorporate it and they will say: "Can I also do this as well?" You know, they come with so many ideas of their own.*
>
> *I also learn from you [the teacher]. It's nice to find out new things and we help each other. It's good that we are trying to solve the problem together and analyse it to see what can be done. It's not all black and white. So it's not all teachers [who are difficult], but some of them.*

This supports the argument for a partnership between teachers and therapists, with mutual respect for one another's knowledge and skills, if support is to be effective.

8.2.2.3 Power dynamics

Therapists acknowledged that their relationship with the teachers was profoundly affected by what was perceived as an unequal power relationship. The therapists spoke of how the teachers interpreted their advice as criticism:

> *And I think sometimes teachers find an occupational therapist as … somebody who "knows better and criticises me". They feel threatened if you enter the classroom Maybe you're just going to find out something.*
>
> *It sounds like there is some internal conflict with some of the teachers. They think you've come to criticise them … In other words "I'm a teacher … I mean, here comes this therapist with all their stories".*
>
> *[I] have been at the school for quite a long time and I think the people should all know me by now and not feel threatened. But it's not happening.*

Even where communication had improved they pointed out that there were teachers who were not approachable:

> *Everybody is talking, from top and from the bottom. More colleagues are talking to fellow colleagues. But those who don't have the will, you can't break through that wall.*
>
> *Isn't the problem perhaps that the teachers don't get from the top the same input that's being given to us from the top? Then they can also start to realise that they owe it to the learners. They are there to try and achieve the best they can for the learners. That they will have to give cooperation from their side as well.*

Therapists pointed out that being based in a special school made it more difficult for them. They felt teachers would have accepted their suggestions more readily if they came into the school from the outside, for example from the EMDC, and were not a part of the school personnel:

> *When passing on knowledge to teachers etc they don't take it seriously as you are there to continue the next day in the special school.*
>
> *They would not take you for granted if you weren't based here.*

So you are there with the necessary expertise and knowledge that can be helpful to them, but they don't want to ask for it, "Because they feel they don't want to be taught by their own colleagues". Those were their own words … And you feel frustrated as a therapist because you want to reach the child, but you first have to break through that wall of obstinacy.

If somebody else from outside [gives the training], someone from outside the school, then it's positive and it's accepted.

I think it is because they don't want to be led by their own colleagues. So they would rather go and look outside.

They said their work should be co-ordinated at EMDC level and not at individual special schools as this would clarify their role as a part of the EMDC support team. They felt that it would be easier if they could come into schools from the outside, taking away the pressure of demands from specific teachers and demanding principals.

These findings of the relationship between the teachers and the therapists highlight the complex power dynamic with issues of mistrust and inequitable power relations. There does not appear to be mutual respect for their skills and knowledge. As a result therapists, in their attempts to give indirect support, are frustrated that teachers do not implement what they have suggested and are aware of teachers interpreting their support as criticism. Although the therapists indicated that it was easier to give support to teachers in ordinary schools, therapists mentioned that they gave very little support in ordinary schools. Thus the relationships with teachers in ordinary schools would be less intense than with teachers in special schools.

8.2.3 Therapists' support for parents

Therapists spoke of the need for them to provide parents with training as they were doing activities with the learners that the parents could take responsibility for at home, for example doing stretching exercises with their child:

As a parent it is your responsibility to raise your child optimally … so things like stretching need to be part of daily routine.

However, some therapists argued that they were not given time in the course of the day to work with the parents and pass on their skills to the parents and emphasised their need for time to be allocated for regular meetings with parents. They suggested that if management allowed them time in their working day, with flexibility in their use of time, they could organise workshops such as a wheelchair workshop for the parents. Careful planning to ensure the participation of parents, who usually find difficulty with attending school activities, was emphasised.

Additionally, therapists suggested that where there were socio-economic problems in the community, through linking closely with the parents, they suggested they could make a difference to the community.

The focus of the therapists was on their support for the teachers. Consequently the importance of building the relationships between the parents and the therapists was not emphasised. Many therapists working in schools have little contact with parents as indicated in Chapter Five. The daily programme that therapists are expected to follow in most of the special schools does not include time to plan workshops or interact with the parents. Improving this relationship would strengthen the development of inclusive and health promoting schools and the link between the school and the community.

8.2.4 Therapists' direct support for learners

Therapists wanted to continue giving direct support to learners. They emphasised that while there were some skills that could be learnt by the teachers and parents, other skills could only be performed by a specialised therapist:

> *But then there are a few things that you've been trained to do as a therapist that the teacher can't do in her class. The same is true for the speech therapists. There are certain things that they've been trained to do that the teachers simply can't do themselves. That's what sets you apart as a specialist from the teacher. So the things that can actually work, we pass on and we try to integrate it with all these specific results. And it was quite unique if we have to say to them: "Look this child can't benefit just from what you are doing for him in the classroom. He will have to come to us for therapy for such and such a reason."*

Therapists remarked that teachers had very high expectations of how direct therapy would benefit the child:

> *A lot of the time the teachers are expecting a quick fix. They are not really prepared to go the whole way with you and the child. It's like, if the child doesn't have good balance then go to the OT, and she will see him.*

Therapists pointed out that in spite of changes in policy and its emphasis on indirect support, direct support was still used extensively with each learner. Some therapists indicated that they only use the approach of withdrawing the learner for therapy, never doing anything in the classroom.

They indicated that this was, firstly, the result of their training which focused on direct support, treating individual children, and, secondly, as a result of the way their day was structured as a consequence of expectations of management who measured the therapists' workload according to contact time with learners:

> *[We are] tied to continuing contact time with individual learners because that is the current school set-up.*

They pointed out that time was needed to develop indirect support. However, no time was allocated during the school day for therapists to write up programmes which could be used by teachers.

In addition, therapists mentioned that there was a demand from other members of the school personnel for direct support:

> *Teachers, psychologists and parents all feel the learner is at school for therapy.*
>
> *My experience is that the teachers are still very traditional.*
>
> *Many teachers are not interested in [attending] workshops.*

The therapists recommended that teachers and others working with the learners are informed about therapists' role changing to mainly indirect support. They indicated a need for the value of indirect support, including the therapists' participation in class discussions to be recognised.

The confidence that therapists have in their ability to give direct support is not matched in relation to giving indirect support. As identified, this is in part the result of their training and in part the result of the current system for giving support, including the organisation of the support service and expectations from school management. The emphasis of teachers and management on direct contact with learners in many special schools needs to be challenged to enable therapists to shift to far greater support for the parents in line with the changes in education policy where the roles and responsibilities of parents in education are emphasised.

8.2.5 Therapists' support for the school system

Therapists spoke of how the education policy of inclusion still needed to be implemented. They mentioned that there were learners with severe physical disabilities attending special schools who were excluded from classroom activities as teachers had not made adaptations to the curriculum to enable them to participate. In essence these learners did not have full access to the curriculum in special schools:

> *People don't understand what inclusion means.*
>
> *Inclusion doesn't happen here [in the special school]. Children with physical disabilities are not being included in class in the special school.*

They pointed out that, despite regulations to ensure that the decision to admit a learner to a special school should be made at the EMDC level, the special schools were still doing their own admissions:

> *At the moment the schools are still selecting the children. There needs to be a panel who assess and decide where the child goes but at the moment this is all being done here … We are admitting many illiterate nine and 10 year olds.*

The therapists indicated that they were concerned and frustrated that the special schools were not being developed into resource centres:

Pilot resource centre – all talk at the moment.

Therapists felt frustrated with the slow implementation of policy. The policy of developing special schools as resource centres had not started in their schools, even in the form of a pilot project. This is different to what was reported in Section 5.2.2.7 in the survey two years earlier when the concept of resource centres was still new and at that time many therapists indicated the schools were developing into resource centres. They were aware of barriers to learning within the special schools related to access to the curriculum, but their own role in whole school development was not clearly articulated.

8.2.6 Therapists' needs for support

Many therapists indicated how they also needed support for the stress they were experiencing with the changes taking place related to the implementation of the inclusive education policy.

It would reduce stress if our roles were spelt out.

They felt frustrated and dissatisfied with what was happening in the special schools where they were working and the demands that were put on them. Many of the therapists had specialised therapeutic skills to provide direct support, which they had developed through experience and through further training. Their prime interest appeared to be providing direct support and it was a challenge to move to a model of indirect support, doing activities that they might not be interested or skilled in doing. They indicated that they did not have training to do this. However, they were willing to make changes if they could be given more responsibility and if tasks that did not need their skills were taken away from them:

[I feel] very frustrated.

We are professional people and we need to be allowed to be given responsibilities.

Being given time to make phone calls.

We need to have school nonsense taken away like interval duty and supervision of children … [I] don't mind being involved in the school but it is a waste of professional time.

The therapists emphasised their need for support, indicating that they felt the EMDC was not providing them with support:

We also need support.

We don't say we need support but we need to cope with the changes.

We do not have an immediate line manager.

The EMDC structure is for educational psychologists.

The therapists spoke of how it would be helpful if they were more aware of the plans for implementing policy and their role in the new organisation of the support service:

We are adapting and making plans but it is nice to know this is the overall plan and that someone at the EMDC will say okay and go with it … Even if there is someone with the plan they don't seem clear and create the map while drawing it.

The process of change with the development of new education policies, but without clarity as to how these policies will be implemented, has resulted in strong negative feelings amongst therapists, and high levels of stress. They identified poor communication between the education management and themselves as contributing towards this, highlighting the importance of keeping all personnel informed of the process of change and in particular of ensuring that all have a common vision and goal of an inclusive and equitable education system. My own experience of working with the national Department of Education working group on Screening, Identification, Assessment and Support suggests that the development of guidelines for implementation

of inclusive education has been far slower than anticipated. Pilot projects to develop full service schools and resource centres have been slow in getting off the ground without the necessary tools for the schools having been developed. It appears that senior managers are themselves stretched to their limit, and may be needing capacity development to be able to interpret and implement the new policy.

8.2.7 Summary

These findings highlight the concern that the support therapists were able to give to teachers in the special schools was dependent on their relationship with the teachers, and the complex power dynamics in this relationship. It was not clear that teachers always wanted support from therapists who suggested that some teachers viewed their advice as criticism and seemed afraid of appearing ignorant. Poor working relationships between teachers within schools also affected the support therapists were able to provide. This theme around the relationships highlights the need for a partnership between teachers and therapists to ensure support is effective. The relationship between therapists and teachers in ordinary schools is in its infancy.

Therapists put little emphasis on developing relationships with parents. The rigid structure of the workday and the school management's prioritising of contact with learners and direct support, made it difficult for therapists to find time to interact with parents. The development of a relationship between therapists, teachers and parents, in the form of real partnerships, would result in more appropriate support being provided. It can be argued that it would enable therapists to play a role in the development of social capital, an important potential effect of the development of inclusive and health promoting schools.

Therapists need to move beyond the medical model with its focus on identifying factors within the learners, such as impairments, as the only cause of barriers to learning, and identify factors at all levels of the education system. Therapists do have specialised skills that have taken many years to attain and that they find difficult to teach to others. However, there is a particular need for health promoting support for the curriculum and

environment. Additionally, to enable therapists to make this shift, the other school personnel need to be informed of the role changes.

Finally, the therapists' frustrations and the effect of the stress on their wellbeing as a consequence of the slow process of implementation of the new education policy, and the difficulties with managing the processes around change, have been highlighted. Early in the development of the inclusive education policy there was recognition that there would be difficulties associated with the change in roles of education support personnel. In 1997 the Department of Education specified that they must be given support to address their "anxieties and attitudes" (Department of Education, 1997: 84). This needs to happen.

8.3 COMPETENCIES THERAPISTS NEED TO PROVIDE APPROPRIATE SUPPORT

In the following phase of the action research, in 2004, approximately a year after the first workshops, two follow-up workshops (Workshops 2a and 2b) were held with the school therapists from the two selected EMDCs. At these workshops the findings of the focus group discussions with parents and teachers, that had taken place in the interim, were presented to the therapists. Following this presentation the therapists went through a second process of identifying the support that they felt the teachers and parents needed. Using this information, the therapists then identified the competencies required to provide this support. Therapists stressed that the competencies they needed in order to provide appropriate support to learners in school were different from those needed by therapists working in a health care environment. They identified competencies therapists need to provide appropriate support to parents, teachers, and to the education system. These competencies have been grouped into those related to knowledge, skills and attitudes and are presented in Sections 8.3.1 – 8.3.3.

8.3.1 Knowledge

Policy: The therapists recognised the need for knowledge of the general education policy; Education White Paper 6 and the Early Childhood Development (ECD) policy; the barriers to learning and development identified in the White Paper; the differences

between providing support using the medical approach and the social approach; and the role of teachers in the assessment of learners.

Curriculum: The therapists recognised the need to have knowledge of the curriculum or the RNCS; the expected outcomes for each level/grade; what is expected at each level/grade; and when tasks or activities are done in a specific term, so that their support could be appropriate.

Child development and disability: The therapists recognised the need for knowledge of different causes of impairments and disabilities and of child psychology.

Evidence of best practice: The therapists recognised the need for knowledge of changes taking place in therapy practice internationally and evidence of effective practice.

Community: The therapists recognised the need for knowledge of the communities that learners come from; the social and cultural differences within the communities; value systems of the community members; and various ways of parenting.

Resources: The therapists recognised the need for knowledge of the resources available in the local and broader community; the education, health, and welfare services available, including those provided by NGOs; how to access resources, for example government social services; and whom to network with in the community, from the community organisations.

8.3.2 Skills

Communication skills: Therapists recognised the need to have good communication skills including *"people skills"*, in particular with teachers and parents.

> *The biggest barrier is the lack of communication between me [the therapist] and the teacher.*

Acknowledging the overlap in the work of the different therapies, they recognised the need to be able to explain what support they can give parents and teachers; how the support of the disciplines differs; why it is important; and how parents and teachers could access support.

> *A teacher asked one therapist who had been working in the school for several years: "What are you actually doing in the school?"*

They recognised the need to explain the inclusive education policy to teachers and parents; how changes in policy have affected the roles of the therapists; and what direct support, in the form of one-on-one therapy, the learners would receive.

They recognised the need to teach their skills to others; explain a diagnosis and its implications; and communicate without sounding paternalistic or authoritarian, using terminology understood by parents and teachers.

> *We struggle with teachers' attitudes to us as they see us as authoritarian … [as if] you know best …*

In addition to speaking skills, therapists recognised the need for good listening skills, especially with parents; hearing and acknowledging the parents' goals for their children and the particular skills their children needed, at home and at school, before planning support:

> *… not our [the therapists'] fancy aim and plan …*

Although therapists recognised the importance of speaking and understanding the language of the parents and the learners, including Xhosa, alternative and augmentative communication (AAC) methods, Sign Language, and Braille, they acknowledged that at times it may require the ability to work through an interpreter.

The therapists recognised the need to communicate effectively to develop an effective working relationship with the teachers and the parents and to negotiate with teachers and parents.

Curriculum adaptation skills: They recognised the need to be able to work within an inclusive education framework and the RNCS; to develop a forum for discussion between teachers and therapists on the curriculum; to involve teachers in assessment of learners to identify what level of support is needed; to design programmes with the teachers that are appropriate to the curriculum so teachers do incorporate them; to collaborate with the teacher to develop creative programmes; to adapt an intervention for a particular learner; to provide appropriate assistive devices, so learners have opportunities to participate in the classroom and school; to ensure that the assistive devices are used and maintained effectively by the parents and the teachers; and to provide information to teachers in ordinary schools so they can make appropriate adaptations to the curriculum.

Skills to identify and address barriers to learning: They recognised the need to be able to help teachers identify barriers to learning in pre-school and in school; to identify when a learner is not being included; to identify barriers to learning in the environment; to assist the teachers through making them aware of the impact of the environment on learning; to adapt the environment to address the learners' needs; to address specific barriers to learning, for example barriers experienced by a Deaf child or who is blind.

Skills to provide direct and indirect support for learners: They recognised the need to move from the medical model, which they said more experienced therapists used, to the social model which has been advocated; to move away from the focus on changing the learner through individual or group treatment to one of primarily changing the environment and giving support to those who have more frequent contact with the learner including the teacher and the parent.

They recognised there were discipline specific skills that they needed to be able to give indirect support, for example the skills to teach parents and teachers how to lift and move

learners with physical disabilities; as well as needing core skills, for example, to plan, present, facilitate and run groups or training workshops for parents and teachers; and the skills to guide and to inspire others.

Nevertheless there was still an emphasis on directed support in the findings. They described a close association between having skills for direct and indirect support. For example, they needed to have specific skills to perform holistic assessments to identify the support learners needed in order to give indirect support to teachers or parents; and to work with learners on a one-on-one basis to ensure that particular activities were appropriate for learners before expecting the teachers or parents to do them. They recommended that they share their skills by having an open-door policy so teachers or parents could observe the therapy; to work in the classroom; and to work with large groups of children.

Skills to facilitate the empowerment of others: They recognised the need to be able to facilitate the empowerment of others including teachers, parents and the community members; and to know how to share responsibility so parents and teachers could be proactive.

Teamwork skills: They recognised the need to be able to participate in multidisciplinary, multifunctional teamwork; to work collaboratively with others in the team towards a common goal; to participate in formal multidisciplinary meetings; to actively include the parents in the team; to acknowledge and state their personal limitations; and, along with the rest of the team, to be able to take whole-school development into account.

> *It is difficult for therapists to come up with a model alone.*

Networking skills: They recognised the need to be able to network with others, including hospital therapists; to work collaboratively with therapists and doctors at the cerebral palsy clinics; to facilitate the access of teachers and parents to community resources,

doctors, and hospitals; to ensure that parents gained access to specialised medical clinics, for example genetics or eye clinics; to build the network between the schools and people in the community, in order to make improvements in the community; and to make links with community organisations, including local business; and to facilitate work placement for learners.

Organisational skills: They recognised the need for organisational skills; to be able to consult; and creativity skills:

> … *thinking out of the box. Don't be a boring person.*

They recognised the need to be able to problem-solve; to prioritise; to delegate; to refer problems they could not solve to others; to be able to co-ordinate activities; to have strong leadership skills; and to be assertive yet flexible and adaptable:

> *... to be able to think on your feet, be prepared, but be able to adapt to the situation.*

They recognised the need for time-keeping skills; technical skills; computer literacy skills; to be able to keep accurate records and write reports; to be able to drive; and to be able to do fundraising.

Support or mentoring skills: They recognised the need for support or mentoring skills; to be able to mentor and to provide support to other therapists, teachers and parents; to support colleagues who struggle with the process of change; to run support groups for parents; to identify parents who are experiencing emotional difficulties; and to provide counselling and emotional support to parents.

> *There are quite depressed parents.*

Advocacy skills: They recognised the need for advocacy skills; to promote inclusive education; to become involved in advocacy campaigns in the community that promote inclusion; and to gain the support of the community for advocacy campaigns.

8.3.3 Attitudes

Acceptance of diversity: They recognised the need to be accepting of the learners, the parents and the teachers; to accept differences and diversity; and the ability to be tolerant and non-judgemental of others.

"A people's person": They recognised the need for them to have a desire to work with other people; to be empathetic; to be sensitive; and to be able to reinforce positive aspects of other members of the team without competing.

Self-motivated: They recognised the need for them to be motivated; to have a positive and creative attitude to their work; and to remain inquisitive about new developments including professional developments.

Adaptable: They recognised the need for them to be adaptable to change and to have a positive attitude to the shift to providing mainly indirect support.

8.4 CONCLUSIONS

The model of support advocated by the Department of Education involves a radical re-orientation of the roles of the therapists and the competencies they need for these roles. It is the shift from highly specialised direct support for individual learners to the introduction of a community-based approach to support. This support will be most effective within a team approach, as will be possible through the district-based support team. It is support that needs to be given to all levels of the education system. It includes the support for developing healthy school policy; support for developing healthy environments; support for developing the link between the school and the community; and support for developing personal skills. These are strategies directly linked to the health promoting schools framework. There is the acknowledgement that this involves

the re-orientation of the therapists' roles. But this approach to support poses challenges to therapists, teachers and others in the school system, parents, and training institutions. The development of appropriate competencies will be essential.

The discussion and reflection on the findings that are presented in Chapters Five to Eight, are presented in Part Three, Chapter Nine.

PART THREE

SYNTHESIS AND CONCLUSIONS

CHAPTER NINE

DISCUSSION

My research has highlighted the gap between the policy of an inclusive education system for South Africa and the implementation of this vision. The roles and responsibilities of the therapists and the competencies they need to support schools within this policy context were investigated. In this chapter, I synthesise the findings of the study with the literature review, describing how I have met the objectives of the research and answered the research questions.

To answer the first research question: "What is the most appropriate way for the therapists to provide support services for schools in South Africa?" two objectives were set:

- To describe the current roles and responsibilities of therapists in the support system for schools in the Western Cape Province.

- To explore the future roles and responsibilities of therapists in terms of how they could provide support within the framework of the development of inclusive and health promoting schools.

To answer the second research question: "What competencies do therapists need to support schools in South Africa?" one objective was set:

- To identify the competencies required by therapists to identify and address barriers to learning in schools.

My hypothesis is that school-based therapists can provide support to schools most effectively by working together with other members of the district-based support team,

within a health promoting schools framework. I believe that this will facilitate the implementation of the policies related to inclusive education. Therapists therefore need to have appropriate competencies to develop health promoting schools in order to give the most effective support to the teachers, parents and the school system, as well as competencies for the provision of direct learner support.

In Chapter Three I described the vision of an inclusive education system that is contained in the education policy in Education White Paper 6. I referred to the role an inclusive education system could play in the development of a democratic and just society (Department of Education, 1997, 2001, 2003a). This is a dream many South Africans believe in. It is the dream that all children will have the opportunity to attend school, and that all children will be able to participate in the process of learning and development. It is the dream of an effective education system. But how realistic is this dream? Must it remain a dream? How do we bridge the gap between policy and reality, bearing in mind the significant challenges to the implementation of an inclusive education system?

In this chapter I will highlight challenges to implementing an inclusive education system including findings from this study reflecting these challenges. More importantly however, I will demonstrate that there is support for an inclusive education system. I will explore the future roles and responsibilities of the therapists and present the competencies therapists need to provide appropriate support.

9.1 DIFFICULTIES WITH IMPLEMENTING AN INCLUSIVE EDUCATION SYSTEM

In 1994 the first democratic election was held in South Africa inspiring many internationally. South Africans previously deprived of their rights, had great hopes and expectations for a brighter future. In the wake of the publication of the human rights based Constitution, in 1994, and following extensive consultation, many progressive new national policies were developed. In the education sector the significant documents included the South African Schools Act in 1996 (Republic of South Africa, 1996); the Report of the NCSNET/NCESS in 1997 (Department of Education, 1997); and the

Education White Paper 6 in 2001 (Department of Education, 2001). Expectations were raised that there would be quality education for all. The fragmented inequitable, race-based education system was unified into a single education system. However, more than ten years later huge inequities remain.

Chisholm describes the perception many have that the education system has deteriorated since 1994 (Chisholm, 2005). Teachers are overburdened as a result of overcrowded schools, with approximately 60% of teachers, nationally, in rural areas and in urban informal areas, having classes of more than 46 learners. In the Western Cape Province 30% of teachers teach classes with more than 46 learners. A high proportion of teachers have more than the recommended 25 hours per week contact time. This is supported by the findings of this study where many teachers worked at school over weekends. As Chisholm highlights, large classes and extended contact time with learners result in increased workload demands and, as a consequence, ineffective teaching and increased levels of stress amongst teachers.

It is well recognised that socio-economic problems are major barriers to learning in South Africa with UNESCO describing poverty as “the most significant of the many persisting barriers to the development of quality basic education globally” (UNESCO, 1999). In South Africa, it is acknowledged that the social conditions need to be addressed for successful education to take place (Chisholm, 2005). The teachers in this study identified many problems related to poverty which affected learning and teaching, including unemployment, illiteracy amongst parents, violence, teenage pregnancy, and drug abuse in the homes and community. These problems are also highlighted by Chisholm (2005) who emphasises that access to quality education has largely changed from a racial to a social class differentiation, though race and social class differences are interlinked. Racism and hidden forms of discrimination continue. For example, separating learners into different school classes according to language can, in itself, act as a form of separation according to class and race.

Schools in poorer communities, which constitute the majority of schools, have greater difficulty providing quality education. Some schools in rural areas still have no water, inadequate sanitation, collapsing ceilings, and broken windows. Rural communities lack basic facilities such as good roads and electricity and seldom have the knowledge or skills within the community to maintain the facilities that they have in the schools. Poor families may not be able to pay even low school fees. Perry and Arends (as cited in Chisholm, 2005) indicate that in 2003 more than 50% of appropriately aged learners were either out of school or had been held back in primary grades. In 1997 20% of learners aged 14 to 18 years were in primary school.

The findings highlight the difficulties that teachers experienced and the gap between the policy of inclusive education and its implementation. The RNCS (Department of Education, 2002), which is based on the principles of social justice, a healthy environment, human rights and inclusivity, was criticised by teachers. Many teachers in this study, including those who previously worked in separate special classes, indicated that they needed support with the curriculum that included: adapting the content, presentation and evaluation; managing the increased administrative tasks; working with learners who were not being taught in their mother tongue; teaching Deaf learners who needed to learn in Sign Language; and identifying how barriers in the physical environment of the classroom or school impacted on the learning process. Teachers felt unsupported in their attempts to adapt and implement the curriculum. They found it difficult to teach a diverse group of learners and were concerned about an increasing number of learners with behavioural and learning difficulties. Large numbers of learners were still struggling to read when they completed primary school. It is fair to say that many teachers in this study did not view diversity as an enriching experience either for themselves or for the learners.

Teachers were extremely anxious about the additional roles and responsibilities that were expected of them and the impact this had on their time for teaching. They were concerned that giving extra support to some learners would reduce the time they had for teaching the core curriculum. Teachers resented therapists putting demands on their time to implement

programmes with particular learners when they already felt overwhelmed. They were largely dissatisfied with the support they received, or lack thereof.

As a consequence, many teachers in this study were opposed to the implementation of an inclusive education system. The question must be asked, in view of such widespread concern by these teachers with the implementation of policy, how realistic is the education policy in the South African context? Is it, in practice, as the teachers suggest, replacing an inequitable system based on race by one based on class? Difficulties with the implementation of inclusive education have been experienced internationally (Brown & Wills, 2000; Carrington, 1999; Slee, 2000; Vayrynen, 2000). Nevertheless, it is still regarded as a process for bringing about a more just society with the proviso that there are adequate and appropriate support services (UNESCO, 1994).

The findings also highlight the difficulty with access to therapy. Amongst the learners, access to therapy was only possible for learners of school-going age who were attending special schools or through private practitioners. Families of children who were out of school found gaining access to therapy very difficult. Prior to entry to school, therapy is provided by the Department of Health or NGOs but therapy is seldom available for the children at the primary health care level through the community health services. There is no co-ordination between the therapy services for children of school-going age provided by the health and education sectors. Only 25% of the therapists in the survey, who indicated that they worked with pre-school and school-aged learners, were employed by the WCED or school governing bodies to work in the special schools. The remaining therapists were in private practice. Seventy four percent of therapists working with pre-school and school-aged learners were working in the four EMDCs in the Cape Metropole. Special schools in better resourced areas were able to employ additional therapists in governing body posts, generally funded by higher school fees. This highlights the inequitable access to therapy between those who can afford private therapy, or a special school with higher school fees, and the majority of families who cannot. However, the greatest need for support from therapists is in poorer communities where large numbers of children experience barriers to learning. In my research, in the Rural EMDC, there was

only one part-time physiotherapist employed by the WCED in the whole EMDC. To address this inequity, a problem highlighted by therapists, teachers and parents, will require additional human and financial resources, including employing additional therapists.

> The challenge [for the education system] is to ensure that learners in the deprived inner areas of the cities and remote rural areas have the same access to the acquisition of knowledge. To eradicate inequalities within the education sector, attention should be paid to the distribution of resources, because skewed distribution of resources results in skewed access to knowledge acquisition. This would be a critical first step. (Phurutse, 2005: 17)

In the findings therapists with little or no training on the curriculum or teaching methodology indicated that they found difficulty with giving teachers support for the curriculum. Therapists indicated that they had a very complex relationship with teachers which affected how the support they gave was acted upon. Likewise, teachers indicated that this relationship made them feel angry, frustrated and disempowered.

Despite the difficulties in the education system, the findings demonstrate that all parents desperately wanted their children included in the education system. They emphasised that even children with multiple disabilities needed opportunities to learn and develop. Education White Paper 6 (Department of Education, 2001) estimates that at least 260,000 learners with disabilities are out of school in South Africa. This violation of the right of all children to education is found in many developing countries (Ahuja, 2000; United Nations, 1948, 1989). In South Africa it is a violation of the children's Constitutional right to education (Republic of South Africa, 1994). If the policy of inclusive education is implemented all children will be able to attend school and participate in the curriculum.

The question may be asked: Do parents of children with disabilities want their children to go to ordinary schools? Although many parents in the Western Cape, together with Inclusive Education Western Cape, an NGO of parents of children with disabilities, support the inclusion of learners in ordinary schools, this was not discussed by many of the parents in my study.

The first focus group was with parents from a poor socio-economic community whose children attended a special school. It was a community where, in the past, and possibly still now, inclusion of learners with disabilities into ordinary schools happened by default and without support. The second focus group was with parents of children who had been refused entry into special schools because of their severe disabilities and they did not discuss the option of inclusion in ordinary schools. The main concern of these parents was that the school community needed positive attitudes towards children with disabilities. Parents highlighted the negative attitudes to children with disabilities at all levels of society – within their communities, the education system, in ordinary and special schools, amongst teachers, therapists, learners and even their own negative attitudes. Negative attitudes to diversity have been identified by the Department of Education (1997, 2001) as key barriers to learning. The third focus group was with parents of Deaf children. The Deaf community in South Africa, unlike other organisations of people with disabilities, favours a separate learning setting for Deaf learners to enable them to learn in Sign Language, their mother tongue, and experience Deaf culture. Inclusion in ordinary school could even be viewed as a form of exclusion, with no one to communicate with. In this study parents of Deaf children, who spoke of their children attending ordinary schools, emphasised that the children needed to have appropriate skills and attitudes to cope in an ordinary school, as did one Deaf learner who was in an ordinary school but had communication skills as well as self-confidence, and, in this instance, a very supportive family.

Parents' views in this study cannot be generalised to all parents of children with disabilities. Identifying parents' support of, or opposition to, inclusion in ordinary schools was not the purpose of this study. The development of an inclusive education system includes the possibility of learning programmes happening in different settings including ordinary schools, full-service schools and special schools/resource centres (Department of Education, 2001). Support can happen at any of these settings. Identifying the nature of this support was the purpose of this study, not where it would happen. The Department

of Education (Department of Education, 2005) emphasises the need to identify the support needed and wherever possible provide it at the ordinary local school.

While support is only available to learners in special schools it may be difficult for parents to envisage, firstly, how their children would cope in an ordinary school without the support of therapists or, secondly, how the parents would cope without the support therapists give them. As implementation proceeds and structures and processes are put in place to provide support this is likely to change. This need for support services in an inclusive education system is highlighted internationally (UNESCO, 1994; United Nations, 1993a) and in South Africa (Department of Education, 1997, 2001; Lazarus et al., 2000; Republic of South Africa, 1996).

In a study that identifies "needs" it is likely that one will end up with a picture that appears very negative. The findings and literature I have presented paints a picture of a crisis in the education sector. This needs reflecting upon. A real strength that I have identified in this study is the extent to which therapists are grappling with understanding their changing roles. They indicated that they are prepared to take up this challenge. At the workshop with the therapists the needs that the teachers and parents identified were presented to the therapists and they were keen to find out more. They want to be active participants in the implementation of inclusive education. Although there is a gap between the policy and implementation of inclusive education, there is still a sense of hope amongst many teachers and therapists that it will be possible. It will be a great loss for education if this window of opportunity is not used.

The statistics give a depressing picture of the state of the education system. The gravity of the problems faced by the schools lacking in resources must not be downplayed. However, the other side of the picture is what is happening on the ground in specific schools in the Western Cape. In the findings of this study many teachers spoke of their commitment to the schools, being prepared to stay after school and over weekends to develop sports and other enriching cultural activities. Teachers at special schools organised sporting activities with learners from ordinary schools so the learners could

interact socially. Teachers at special and ordinary schools were keen to increase their contact with the parents. They were willing to make physical adaptations to the schools to accommodate learners with physical disabilities.

Parents emphasised the value of the support they had received from therapists once their children were in the school system. They spoke of the development of their children's skills, in particular communication skills, movement skills, and life skills.

There are also reports that what is happening in the health promoting schools in the Western Cape Province is very positive (UWC HPS Forum, 2005). School nurses describe schools involvement in many projects including school gardens and de-worming projects; and involvement in the community including computer literacy and soup kitchens. These schools, often in poor socio-economic communities can embrace the value of inclusion and become inclusive and health promoting schools.

In summary, in many ways implementation of an inclusive education system in South Africa, with its overwhelming socio-economic problems, can appear an impossible task. Teachers are under an enormous amount of stress and feel largely unsupported. Therapists are aware of the gaps in their abilities to support the learners, teachers and parents. Nevertheless, parents desperately want their children to be included in the education system. In spite of this crisis in the education system there are pockets of excellence including the development of health promoting schools.

In the following section I will propose a way forward for the support services by using the health promoting schools framework within the whole school development approach.

9.2 USING A HEALTH PROMOTING SCHOOLS FRAMEWORK TO PROVIDE SUPPORT

In answer to the question I posed earlier: "How do we bridge the gap between policy and reality?", I first revisit the theoretical framework outlined in Chapters Two and Three in this thesis.

The health and education systems in South Africa need to be understood within the historical and the current global political and economic contexts. With the growth of capitalism internationally, the gap between the rich and poor has continued to increase globally. Likewise, in South Africa, despite the vision to address poverty contained in the Reconstruction and Development Programme (African National Congress, 1994), inequality and poverty have increased, as a result of the government's decision to promote a virtually unregulated market economy.

I am arguing that, in spite of these difficulties, it is still important to support the implementation of inclusive education in South Africa. But it will require radical changes by all who work in schools and all who support the school system, including the teachers, the learners, the parents and the community. The importance of education support services in this process is acknowledged by the Department of Education (Department of Education, 1997, 2001; Republic of South Africa, 1996). I am arguing that to provide effective support the support services need to make use of the health promoting schools framework.

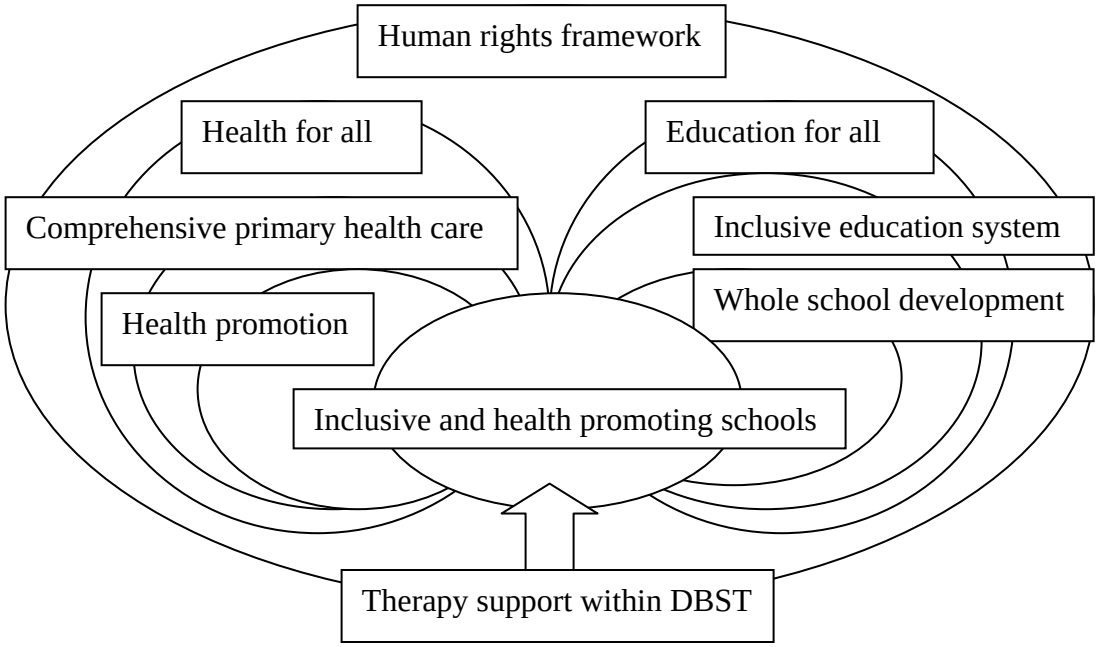
The Report of the NCSNET/NCESS made the recommendation (Recommendation 5.5) that the health promoting schools strategy be adopted at all schools (Department of Education, 1997). Subsequently, the "Draft national guidelines for health promoting schools/sites in South Africa" were produced by the Department of Health (2000) in collaboration with the Departments of Education and Welfare highlighting the need to use a whole school development framework for schools, with the health promoting schools strategy located within it. The development of inclusive schools is equally located within the health promoting schools framework as illustrated in Figure 3.2 (Department of Health, 2000). However, Education White Paper 6 (2001) makes no mention of health promoting schools or the need for a health promoting approach to be used for the provision of support (Department of Education, 2001), nor is the health promoting schools framework referred to in subsequent documents from the Department of Education. The only mention of health promotion by the Department of Education is

the requirement of the district-based support team to “develop general health promotion programmes” (Department of Education, 2003a: 25). The broader approach of the health promoting schools framework is not referred to.

I propose that by thinking globally, acknowledging the broader economic and political constraints, but acting locally within schools, drawing on the support within the school and the community, effective support for inclusive education will be possible.

In Chapters Two and Three I locate the concept of systemic, health promoting support for learners within the broad human rights framework. Chapter Two describes the historical background to health for all through comprehensive primary health care and within it the growth of health promotion including health promoting schools. Chapter Three describes the move internationally and in South Africa towards inclusive education systems, to provide education for all, and the importance of education support services in its implementation. I present literature which argues why health promoting schools are appropriate settings for inclusive education (Department of Education, 1997; Department of Health, 2000; Donald et al., 2002; Lazarus et al., 2000). The health promoting schools framework utilises an ecosystemic theoretical perspective that explains why the relationship between individuals and their social context and the environment needs to be taken into account (Donald et al., 2002; Engelbrecht & Green, 2001; Weare, 1998). It is an appropriate framework for addressing the challenges to the education system in a holistic and comprehensive way. This is illustrated in Figure 9.1.

Figure 9.1: Therapists' support for schools within an inclusive and health promoting schools framework



*DBST: District-based support team

My argument is that therapists, as one part of the education support services, can provide holistic support including effective direct and indirect support by using the health promoting schools framework.

The principles of the health promoting schools framework are broad and holistic based on the Ottawa Charter: building healthy policies; creating a healthy physical and psychosocial environment; building links with the community; developing personal skills of all in the school community; and reorienting of the support services

In Sections 9.2.1 – 9.2.5 I discuss my findings on the roles and responsibilities of therapists within the health promoting schools framework, with a particular focus on the five different components of the Ottawa Charter: development of healthy policy; development of a safe and supportive environment; building of school-community networks and partnerships; development of personal skills; and re-orientation of

education support services (WHO, 1986, 1995a, 1995b, 1996, 1997, 1998c, 1998d). The therapists' support for the curriculum, the purpose of the school programme, is included in each of the components.

The five principles of the Ottawa Charter are practical and realistic, making it an appropriate framework for providing support. It is a comprehensive approach which will provide support to all learners and the school system. This type of support is not a package of selected interventions with the focus on a small number of learners. It is comparable to comprehensive primary health care, with its holistic approach to changing the environment and empowering the community, as opposed to selective primary health care, with its limited package of interventions.

9.2.1 Therapists' role in developing healthy school policy

Developing school policy that supports and promotes well-being is the first component of the health promoting schools framework.

An inclusive education policy has been drawn up in South Africa (Department of Education, 2001) and guidelines for its implementation have been developed (Department of Education, 2003a, 2003b, 2003c). While education policy affecting the whole country is made at the national level, it also needs to be complemented at the provincial level, and at the district and school levels where the local context needs to be taken into account. At all levels the well-being of those whom it affects needs to be considered.

Between 36-46% of therapists in this study, who were working in schools, indicated that they had an influence on the making of policy in the school, but only 7% of therapists were members of a school governing body, despite the provision that governing bodies can co-opt additional members with "expertise" (Republic of South Africa, 1996: 18). Therapists can become more actively involved in developing healthy school policies by participating on the governing bodies. In this study teachers indicated that they had received training to develop specific policies for their schools. Examples of healthy

school policies include developing a safe and accessible environment inside and outside the school, or ensuring that all learners are included in sports, leisure and cultural activities. Alternatively, or in addition, the therapists can work in partnership with parents to advocate for schools to have well resourced, inclusive policies, for example, the inclusion of learners with disabilities or HIV.

At the district and national levels therapists can be more actively involved in developing provincial or national policy through partnerships with community Organisations, particularly disabled people's or parents' Organisations such as the Disabled Children's Action Group (DICAG) and Inclusive Education Western Cape, for example, advocating for learners currently out of school to have access to school. Possible areas therapists might focus on for developing policy are indicated in Table 9.1.

Table 9.1: Examples of areas therapists might focus on for policy development (Booth & Ainscow, 2002; Department of Health, 2000)

All therapists -policies related to:

- co-ordinated access to support services
- therapists working in the classroom
- withdrawal of learners from class for therapy/medical appointments
- collaborative training with staff and/or parents
- parents involvement in therapy, including giving consent
- learners having access to the curriculum
- support for learners who are absent for long periods such as due to chronic illness
- availability and use of assistive devices

Occupational therapists -policies related to:

- positive behaviour management strategies
- raising self-esteem of all in school community
- processes to deal with problems before they escalate

Physiotherapists -policies related to:

- involvement of all learners in physical activity
- prevention of sports injuries

Speech and language therapists -policies related to:

- support for learners not learning in their home language
- interpreters to help learners and school personnel
- training in Sign Language
- monitoring noise levels in the classroom and school

Occupational therapists and physiotherapists -policies related to:

- physically accessible environment: meeting the needs of Deaf, blind, partially-sighted people as well as people with physical disabilities (including learners, school personnel, families and the community)
- accessible grounds, classrooms, toilets
- consulting organisations of people with disabilities

In the findings the teachers and parents highlighted the need for them to know what support the therapists could offer them. The survey identified an overlap between many of the roles of the therapists from the different disciplines. The need for clarification on the role of therapists in schools has been discussed internationally (Boshoff, 2000; Bundy, 1995; Connolly & Anderson, 1978; Dunn, 1988; G. A. King et al., 1999; McDougall et al., 1999). It led to the development of guidelines for therapists working in schools in the USA (American Occupational Therapy Association, 1987a, 1989). In South Africa, all members of the district-based support team need a clear understanding of one another's roles and competencies. South African guidelines on the roles of all in the district-based support team would facilitate their teamwork and ability to provide support.

The need for therapists working in schools to have knowledge of the relevant education legislation has been identified internationally (Coutinho & Hunter, 1988; McEwen & Shelden, 1995; Mitchell & Lindsey, 1979).

In summary, there is a gap between the current and proposed roles of the therapists in developing healthy policy. Therapists need knowledge of the education policy. Although healthy policy is important, it is worthless unless it is implemented. This means that the learners, personnel at the school, support services including therapists, parents and community need to be made aware of these policies and encouraged to act on them. Skills to advocate for healthy policy and to implement the policy will be needed.

9.2.2 Therapists' role in developing a safe and supportive teaching and learning environment

Creating a safe and supportive teaching and learning environment is the second component of the health promoting schools framework.

The environment includes, firstly, the physical environment of the school, secondly the classroom environment, and, thirdly, the psychosocial environment (Donald et al., 2002). The ecosystemic model stresses that the environment may have an impact on learning and can support or hinder inclusion. In a supportive environment diversity is respected and valued: this is an integral value in the curriculum (Department of Education, 2002).

The findings of this study indicate that 11-39% of occupational therapists and physiotherapists were involved in modifying the physical environment of the special schools, for example, installing ramps, rails, adapted toilets and basins inside the school buildings and in the playgrounds. Between 10-54% of therapists were involved in making adaptations in the classrooms. However, very few therapists were giving support in ordinary schools, where modifications might be needed, a need that will increase as more learners with disabilities are included in their local schools. Physiotherapists and occupational therapists have many skills for adapting the physical environment as Bundy (1995) has indicated in the USA. Ordinary schools are frequently inaccessible to learners with physical or visual disabilities as a result of structural barriers such as inaccessible entrances, stairs, inaccessible toilets, basins, or telephones, and door handles fixed at inappropriate heights. In this study teachers, in ordinary schools, indicated that physical adaptations might be needed by learners or their families, but the financial implications would need to be addressed. Therapists, with their specialised training in ergonomics and in identifying barriers in the environment, can recommend appropriate modifications. Most physiotherapists and many occupational therapists in this study indicated that they provided the learners with appropriate seating or alternative assistive devices for positioning, such as standing frames, for use in the classroom. Much advice the therapists can provide related to positioning would benefit all learners, not only those with a disability, and this knowledge needs to be shared with teachers.

Assistive devices are important modifications that facilitate independence and enable learners to get increased access to the curriculum. The findings indicate that many therapists provided learners with assistive devices which promoted learning and access to the curriculum; enabled learners to move from one part of the school to another; enabled them to eat and drink; and enabled them to communicate. Some therapists were responsible for manufacturing, maintaining and repairing these assistive devices and taught the teachers and parents to use and maintain these assistive devices.

Internationally, therapists, such as Dunn (1988), emphasise the importance of therapists becoming involved in adapting the environment, particularly the physical environment, to facilitate better learning outcomes. However, improving the psychosocial environment is equally, if not more, important.

The psychosocial environment refers to the school culture, where barriers resulting from prejudice and discrimination due to social class, race, gender, disability or other differences may arise. Therapists who work in special schools are expected to become involved in general school cultural activities. In this study, therapists were involved in cultural activities closely related to therapy, such as organising horse riding for the disabled (5-33% of therapists), dance therapy (14-21% of therapists), sports for disabled learners (33-73% of therapists) and hydrotherapy (4-52% of therapists), and some cultural activities not usually associated with therapy, that are part of the school life, such as extra-mural activities (14-32% of therapists) including school plays, recycling projects, school newsletters or school outings. However, many therapists who use a holistic approach in their work would say the line between what therapy is, and what it is not, is artificial as all therapy has the broader goal of developing independence.

The self-esteem of all in the school community is an important element of the psychosocial environment. Enhancing self-esteem of all in the school community, including the therapists, is essential for increasing well-being.

Slee (2000), although agreeing that at times physical and human resources are needed to provide support to facilitate inclusion, argues that there is a far greater need to be addressing the school culture, which needs to enable and empower the learner. The culture of the school is reflected in the curriculum. Therapists need to actively integrate the values of the RNCS, social justice, equity and democracy, into their daily practice. Parents are more likely to become active members of the school community if they feel welcomed in a school that celebrates diversity. Many parents feel judged by teachers, other school personnel and therapists for being poor, young single mothers, parents of children with fetal alcohol syndrome, or because of other differences. In this study teachers and parents emphasised the importance of therapists being culturally sensitive, in particular where therapists came from a different language and/or cultural background. Parents' reflections on the support they had, at times, received from therapists, enabling them to accept their own child's differences, suggest that some therapists have very positive attitudes to diversity or cultural competence as described by Jirikowic (2001).

Few therapists in this study were involved with advocacy or with informing teachers and parents of the rights of people with disabilities. However, some school therapists in the Western Cape Province, in partnership with parents, and a community-based organisation of people with disabilities, have a history of successfully lobbying for assistive devices for learners with disabilities at a special school (Struthers, 2001). In 2000 assistive devices were very difficult for children and adults with disabilities to obtain. The orthopaedic workshop which made these assistive devices was threatened with closure. A delegation, including school therapists, parents of learners and adults with disabilities, lobbied the Western Cape MEC for Health and approached the media for support. The outcome not only included the continuation of the workshop, but also an increase in personnel working there, and the immediate improvement in the provision of assistive devices. The role of therapists as advocates for children with disabilities is seldom referred to internationally though the need for therapists to become advocates for learners with disabilities has been highlighted by Jirkowic et al. (2001) and Pollock and Stewart (1998). De Jong (2000) recommends that all who work in education support services need to take up the challenge to address negative attitudes. The promotion of positive

attitudes to diversity and the rights of learners is needed. There is a need for advocacy to become a more important role of therapists. Their lack of involvement suggests not only a gap in their knowledge and skills, but also a gap in their orientation.

In summary, there is a gap between the current and the proposed roles of therapists in relation to their support for developing a safe and supportive teaching and learning environment. Although therapists do have skills in modifying the physical environment, more support is needed to address barriers in the physical environment in ordinary schools. Modifying the physical environment will require financial resources and may not be given priority by the Department of Education while there are schools that still have no running water or toilets. Continued support for the provision of assistive devices is needed. The therapists' role in addressing the psychosocial environment in all schools, including advocating for change, needs further development. These gaps will require further capacity development.

9.2.3 Therapists' role in building school-community networks and partnerships

The third component of the health promoting schools framework involves strengthening community action and building the network between the school and the community.

In the findings of this study, teachers indicated that they wished they could see the parents more frequently, in particular if their children were experiencing difficulties with learning. However, the power imbalance in the relationship between parents and teachers needs to be addressed for parents to feel listened to and heard by the teachers. Teachers were very critical of parents. Parents need to become empowered through a bottom-up approach described by Laverack and Labonte (2000), where teachers and parents reflect together on the barriers and find the solution together. Strengthening the teacher-parent relationship has the potential to develop the social capital in the school community.

Many parents in the study who were involved in community organisations such as DICAG had become empowered as a result of their efforts to have their children included

in school and through parent support groups. They had also facilitated the involvement of other parents in these community organisations and had been involved in promoting the rights of children with disabilities. These parents would form a valuable form of support to the schools. They have skills, and can develop new skills, which could be utilised to provide support to over-burdened teachers (Department of Education, 2003a, 2003b). As Education White Paper 6 (2001: 18) states "the non-recognition and non-involvement of parents" is a barrier to learning and development.

In the findings teachers identified therapists as having the potential to develop the links between the teachers and the parents. Pollock and Stewart (1998) describe how, internationally, parents and teachers believe therapists have an important role to play in collaboration and networking. Many of the more recently qualified therapists in South Africa know of and have had training in the WHO community based rehabilitation approach (WHO, 2003). This has already taken a small number of therapists beyond a curative approach to a developmental approach. However, this approach has not generally been used by therapists working in schools. By using this approach, therapists could identify the local community organisations, and by networking with these organisations they could make contact with parents of children with disabilities who are not yet in school. This is an important role that has been identified by the Department of Education (2003b). In addition, therapists can play a valuable role in making intersectoral links between health and education, with health therapists, nurses and doctors at the community health centres and hospitals. They can establish links with local organisations of disabled people to facilitate the involvement of learners with disabilities, their parents and teachers in these organisations. By building this multisectoral network between the school community, parents and organisations in the community, therapists will have an important role in building a support system that is "flexible and responsive to specific community needs" (Department of Education, 2003b: 8).

Therapists need the ability to identify the social determinants of health that have a negative effect on the health of the school community in order to address barriers to learning at all levels of the system. It is important that therapists along with other

members of the district-based support team become involved in activities in the community that, as McDonald and Davies (as cited in Raphael, 2000) argue, to enable and empower the parents and other members of the community.

Large gaps existed in the relationships between therapists and parents. Many therapists had never met the parents of the learners they were working with or had only met them when they first assessed the learner. This was particularly true for learners attending special boarding schools. Bundy (1995), Jirkowic et al. (2001), Paradice and Adewusi (2002) and Pollock and Stewart (1998) emphasise the importance of developing a partnership with parents. The policy, in South Africa, for all learners to attend their local school, with appropriate support, would partially address this problem, if support was available at the local school. However, therapists also have minimal contact with many parents of learners who are not boarders. This may be the result of an inflexible school management, or disempowered or uninterested parents, or possibly therapists not prioritising the development of this relationship.

The district-based support team needs to play an effective co-ordinating role to avoid duplication, gaps and confusion in developing the school-community network. This process of creating a strong supportive network between the school and the community would contribute towards building social capital. The development of social capital is emphasised in recent health promotion literature (Baum, 1998; Edmondson, 2003; Hawe & Shiell, 2000; Looman & Lindeke, 2004). The values associated with building social capital, including the creation of trust, encouraging interaction and debate, are important values within the health promoting school.

In summary, my findings indicate that the current role of therapists is largely limited to links with the health sector and a small number of organisations for people with disabilities. Therapists could play a far greater role in the development of the network between the teachers and parents, and the school and the community and consequently building social capital. They need skills to facilitate the empowerment of parents and others from the community so that they can become involved in the provision of support

to schools. I argue that the community based rehabilitation approach is a developmental approach that could be utilised. Although currently involved in some multisectoral links, therapists need skills to establish links with more community-based organisations, in particular organisations of people with disabilities and organisations of parents of children with disabilities.

9.2.4 Therapists' role in developing personal skills

The fourth component of the health promoting schools framework is the development of the personal skills of all in the school community.

The findings of this study indicate that most therapists in special schools were involved in developing the personal skills of the learners through their very broad involvement in life skills development. These included the development of hearing, speech and communication skills; visual perceptual skills; skills for daily living including feeding, oral hygiene, bathing, using the toilet, and dressing; skills for taking care of personal assistive devices; socialisation skills; skills to maintain health and decrease risky behaviours; skills to use transport; skills to respond to an emergency; skills to engage in desired sexual/intimate behaviour; skills for at home including taking care of clothing, cleaning, meal preparation, shopping and money management; motor function skills; skills to participate in sports activities, leisure activities, and play activities. These important activities develop the learners' knowledge, skills, attitudes and insights thus enabling them to interact with society and its challenges (Donald et al. 2002). The development of many of these skills involves direct support.

With the RNCS there are many opportunities for therapists to work in partnership with teachers to integrate life skills development into the curriculum. The findings in this study indicate speech and language therapists were more involved than other therapists in supporting the curriculum, through modifying the curriculum and developing ways of presenting and evaluating the curriculum. Some therapists developed programmes which the teacher could use with the learners. However, several teachers reported disliking and resenting the therapists' programmes which were not viewed as a support for the

teachers, but as providing extra work for the teachers while the therapists' workload was decreased. Integrating support into the curriculum, as opposed to add-on programmes is important for teachers who are already feeling overwhelmed. The learning area Life Orientation, for example, includes health promotion, social development, personal development, physical development and movement, and orientation to the world of work (Department of Education, 2002). Physiotherapists, with extensive knowledge of movement, can advise on physical activity, including modifications to enable all learners to be included. They can advise teachers on developing programmes that promote movement coordination, strength and flexibility in line with specific learning outcomes in the curriculum. They can share their knowledge of the importance of physical activity for the promotion of health and prevention of disease with parents and teachers.

In the findings the therapists indicated that they have a role to play in helping teachers to develop the skills they need to identify and address the barriers in the curriculum that learners with disabilities experience. Although there is a single curriculum for all learners it may be modified or adapted to meet specific needs of individual learners. For example, a learner who has difficulty writing might have a problem with fine motor control and a solution could be using a computer or adapted pen. However, if the difficulty arises from poor shoulder control the therapist might recommend gross motor activities to improve the strength and co-ordination around the shoulder girdle or a specific sitting position that the teacher could use. A learner who has a lot of difficulty speaking may use alternative and augmentative communication provided therapists help the teacher to learn to use this system appropriately, and the learner may be evaluated using written rather than oral work. Setting functional goals is emphasised by King et al. (1999). These skills, which are already being used by some therapists in special schools, should be used more widely in ordinary schools as more learners with disabilities are included in their local schools. Learning these skills would become an empowering process for the teachers.

The findings indicate that collaboration and joint decision making between teacher and therapist in modifying the curriculum was generally poor or almost non-existent. In this study teachers and therapists complained about one another. The models of support

described by Bundy (1995) and Dunn (1988), including monitoring and consultation, require therapists to demonstrate an attitude of respect for the teachers. The importance of developing collaborative partnerships between therapists and teachers is highlighted internationally by Greenwell et al. (1998), Law et al. (2002), McCartney (1999) Santos (2002), Topping et al. (1998) and Wright & Kersner (1998). They indicate that where there is a partnership, effective support by therapists can help teachers change their practice. This support includes the development of relevant knowledge and skills, and the facilitation of changing attitudes. The process needs to be an empowering experience for those who receive the support. However, difficulties arise when moving from the role of consultant where therapists see themselves, and are seen, as experts coming in from the outside, to the role of collaborative partners where therapists and teachers work as equals. These skills need further development.

The findings indicate that teachers wanted further training from therapists to develop their knowledge and skills. For example, they wanted to learn about the different disabilities learners have, to understand why they had difficulties with learning. They wanted skills to help teach reading and writing. Capacity development of teachers has been identified as a priority by the Department of Education (2001). Chisholm (2005) indicates that, in 2000, 22% of teachers were considered unqualified or under-qualified. The Department of Education highlights the need for teachers who are afraid of the process of change to participate in change management skills development. The limited capacity of many teachers is a major barrier to learning and development which affects their ability to implement the changes needed with the curriculum and inclusive education.

Although life skills development for learners can be integrated into all aspects of the curriculum, opportunities need to be made for the development of the personal skills of teachers, non-teaching school personnel, the parents and families. The therapists in the study indicated they had provided training, sharing their knowledge and skills, although some therapists indicated there were some specialised skills they were unable to teach others easily. However, therapists spoke of the reticence of some teachers to learn from

them, and teachers indicated how they resented being given “orders” by the therapists. Teachers, needing an enormous amount of support, felt angry and unsupported, while therapists, with skills, felt frustrated that the teachers were not following their advice. Poor relationships prevent the development of self-esteem and are disempowering.

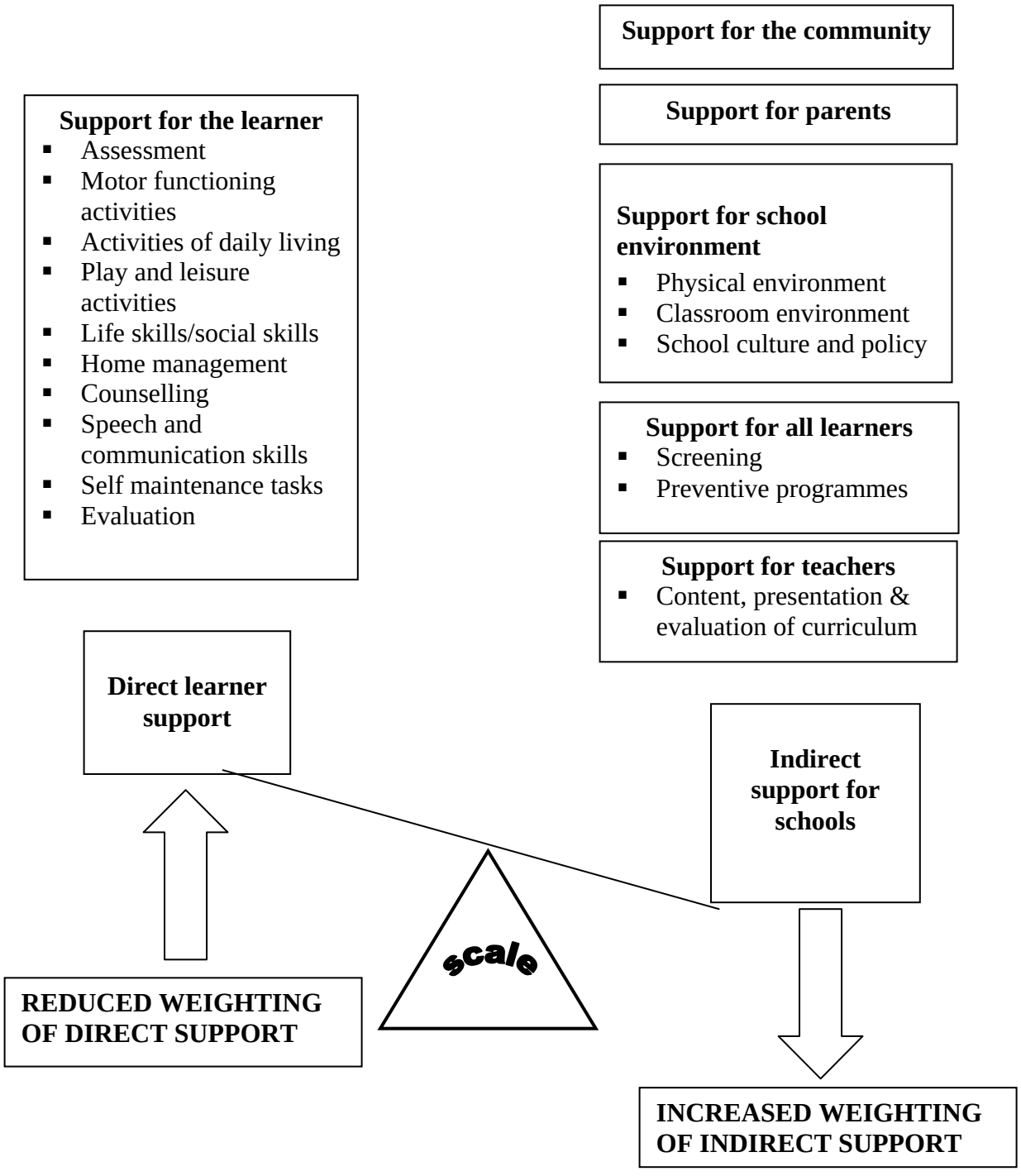
The development of skills to teach adults may help therapists in their work with teachers, non-teaching personnel and parents as has been described by Greenwell et al. (1998), Hirst and Britton (1998), Jirikowic et al. (2001) and Sellers (1980), but the most crucial change that is needed is the development of a relationship in the form of a partnership between therapists and teachers.

In summary, most therapists are currently involved in the development of learners’ skills through direct support. However, this is seldom integrated into the curriculum. Therapists require an understanding of the RNCS to integrate therapeutic activities into the curriculum (Department of Education, 2002). Only a few therapists are involved in the development of the personal skills of others in the school community, including teachers and parents. The current process of developing the skills of teachers is not effective or empowering leaving teachers and therapists feeling frustrated. Therapists need skills to develop collaborative partnerships with the teachers and an empowering adult education approach is suggested. The ability for therapists to develop a partnership with the teachers is essential for support to be effective.

9.2.5 Reorienting education support services

The fifth, and final, component of the health promoting schools framework is the reorientation of education support services to a health promoting approach that focuses on identifying and addressing barriers to learning. This section focuses on the reorientation of the therapists’ support to mainly indirect support, integrating the four other components of the health promoting schools framework. This is illustrated in Figure 9.2.

Figure 9.2: New roles of therapists: Changing the balance of direct and indirect support within a systemic, health promoting approach



As the Department of Education (1997, 2003a) emphasises the main focus of support needs to be indirect support, with direct support only provided if the institution-level team cannot give support. According to the Department of Education (1997) direct support will continue for learners needing specialised intervention to overcome permanent or temporary barriers to learning. In indirect support the therapists will act as consultant-mentors with the focus on the education system not individual learners. The findings indicate that teachers and parents do not understand this.

The findings highlight the enormous range of roles and responsibilities that the therapists are currently undertaking. Consequently their anxieties about changing roles, with the shift from direct to indirect support and the fear of having to take on more work, are not surprising. The process of reorienting the roles of therapists needs to be health promoting, building their self-esteem and well-being. This has been highlighted by New (1998) who emphasises the importance of therapists having a healthy self-esteem and clear understanding of their purpose in the provision of support.

In this study the skills that were developed through direct support included communication skills, movement skills and skills related to activities of daily living including play and work. Absence of these skills may act as barriers to learning. Chapter Eight described Workshop A with the therapists which explored ways to integrate the development of these skills into the curriculum (Appendix Vl). As indicated in Chapter Eight, this process with the therapists and teachers needs to be continued beyond this study using an action-reflection approach. This is discussed in Section 10.4 and illustrated in Figure 4.1.

In the findings of this study one third of the therapists indicated that they wanted to spend a greater proportion of their time on indirect support than on direct support for the learners. However, the extent of the change they wanted was small. Their perception that the teachers and parents wanted direct support was confirmed by them. The emphasis of the school management was also on direct support allowing minimal time for therapists to undertake indirect support. Therapists suggested that one of the reasons teachers and

parents wanted direct support was because they had unrealistic expectations of the difference it would make to the learner. This could be related to difficulties with accepting differences or diversity. Although valuable, difficulties with direct support, including withdrawal of the learner from the classroom, have been described internationally (Bundy, 1995; Dunn, 1990; Harn et al., 1999; Karnish et al., 1995).

The fundamental change that is needed in the approach of the support services is to change the balance from mainly direct support to mainly indirect support. It is not to stop all direct support but to integrate it. It is also a move from a medical model of support to a systemic, health promoting model of support which will enable a far greater population of previously unsupported learners to gain access to support thus addressing past inequities.

The importance of indirect support by therapists, including support for teachers, non-teaching school personnel and parents, was recognised in the findings. As one parent described, the support given to her by a speech and language therapist had taken her on a journey of discovery into the world of the Deaf person:

> *That woman really led me on the right path and made me understand even more because at that stage I didn't even encounter an adult that was Deaf. It was a totally new world to us.*

In the findings many parents indicated their own need for support. This included emotional support and their need for therapists to advocate for the rights of children with disabilities in schools and communities. Teachers identified the role that therapists could play in building a network as important, including facilitating the relationships between the teachers and the parents and between the school and the community organisations. Therapists were already involved in the community with 36-67% of therapists indicating they were involved in early identification of problems related to disability. Many of the therapists provided the community with information on disability, on disabled people's organisations and on organisations for people with disabilities. Between 62-82% of

therapists in the special schools indicated that they were involved with developing their therapy departments into resource centres.

Early intervention by therapists for young children prior to entry into school was emphasised by parents, teachers and therapists in this study. Direct support for children is often more effective at an early age. This suggests that there is a need for therapists to focus their direct support on children in the 0-5 age group. Early intervention, as proposed by the Department of Education (2003a), would ensure that the support would be given to very young children with continuity into their school going years. Direct support for the learners will be most effective if the environment is healthy. This includes a supportive family and local community and also having adequate financial resources. If these conditions are not in place, for example, in poor communities, the results of direct support will frequently be negated. Indirect support, including support for parents of very young children with disabilities is essential. This is the time parents learn skills in handling their children, learning to communicate with their children, and learning to play with their children.

The way in which indirect support is given is crucial to how effective it will be. Support needs to be an empowering experience for the recipient. Reiser (2000: 12), along with other activists in the disabled peoples' movement, points out how the medical model and the identification of "special education needs" disempower parents.

The complex and unequal power relationships between therapists and teachers or parents have an impact on all the support they give and how it is received. In the findings many teachers described therapists as showing a lack of respect and having poor communication skills. Parents, too, spoke of poor communication with therapists, including their inability to speak the language of the parents. They did not know what happened in therapy or what they could do at home or in the classroom. Parents with very little money for transport and with little, if any, experience of getting support from therapists, in addition to feeling disempowered, will have little incentive to approach therapists in the special schools.

Therapists, along with others from the district-based support team who provide support, need to ask themselves: Has their support enabled and empowered the teachers? Has the support given the teacher confidence? Have the teachers been motivated? Has their support empowered the parents? Has their support empowered the learners? How has the whole school system been supported? Have the principals been empowered to mobilise community resources? Empowerment as Zakus and Lysack (1998) describe, needs a strategy that includes reflection and collective action.

The findings indicate that some therapists currently based in the special schools wanted to be based at the EMDCs. This is in line with the policy of the Department of Education for special schools to become resource centres, collaborating with the district-based support teams, to provide support to full-service schools and ordinary schools (Department of Education, 2003b). Therapists were frustrated by school management at the special schools and indicated that their advice was ignored or rejected by teachers with whom they work. They suggested their support would be more readily accepted and consequently more effective if they were no longer based at the special schools. This might be a solution. However, in practice, some therapists, even if based at the EMDCs, would need to spend a considerable amount of their time at these resource centres. The need remains for the therapists to develop their consultation skills to provide effective support to the teachers and parents through collaboration and a mentoring-partnership approach. According to A. Bundy (personal communication, September 2004) therapists in the USA have found this collaborative consultation a particularly difficult skill to attain, in part because they are not trained in this way.

The Department of Education has identified the greatest challenge to those providing support as “the fragmented way in which support is currently provided” (Department of Education, 2003a: 11). The Education Department is advocating for education support services to transform their model of support from a medical approach, with support for a select group of learners identified as having special needs, to a systemic approach, with support for the education system, including all learners, teachers, the school, and parents

(Department of Education, 1997, 2001, 2003a, 2003b). The latter approach is congruent with the health promoting school strategy being promoted in this study.

Support for learners, teachers, non-teaching school personnel and parents will be provided by the district-based support teams (Department of Education, 2003a). The development of multidisciplinary district-based support teams is a challenge for all working in education. Collaboration and teamwork have been identified by the Department of Education, (2003a) as fundamental to successful support. The findings of this study suggest multidisciplinary teamwork involving the therapists was weakly developed in the special schools. Therapists seldom identified the need for support, or planned and evaluated the interventions with other members of the team. Internationally a collaborative and multidisciplinary approach to support has been identified as important for providing more effective support (Department of Education, 1997, 2003a; Dunn, 1990; Engelbrecht & Green, 2001; Giangreco, 1995). In many countries, including the USA, UK, Australia and New Zealand, this collaboration and teamwork is done through the development of Individualised Education Programmes (IEPs) for particular learners (American Occupational Therapy Association, 1989; Hanft, 1988; McEwen & Shelden, 1995; NSWPPA State Council, 1998). Although recognised as important, internationally therapists find multisectoral collaboration difficult (Topping et al., 1998). Likewise, effective collaborative partnerships between therapists and teachers, although difficult to achieve, are identified as essential for successful support (McCartney, 1999).

Within the district-based support team, it is proposed that therapists will assist schools in identifying and addressing barriers to learning (Department of Education, 2003a). Barton (1997) describes how the process of identifying needs involves making a value judgement which reflects the power relationship between the person doing the identification and the person whose need is being identified, and can lead to a disagreement over what constitutes needs. Disagreements can lead to a struggle between professional and client, particularly when the professionals identify needs that preserve a dependent relationship. Struggles between professionals can also arise. Unless the district-based support team is aware of this process in their attempts to identify the

barriers to learning and the needs for support, they may become caught up in the cycle of disempowering the teachers, parents and the learners. Professionals from the different disciplines could well start to compete with one another for posts; for the right to provide support; and in the identification of who has the most appropriate competency profile to provide specific support. The importance of teamwork and developing the team thus needs to be emphasised. Communication within the district-based support team should prevent duplication of support and identify who, within the district-based support team, is the most appropriate person to intervene. It should address the concern that has been expressed internationally, and in this study, about the overlap of the roles of the therapists which can lead to duplication, inefficiency and confusion among themselves and others with whom they work (Campbell, 1997a; Fairbairn & Davidson, 1993). Identification of the barriers to learning and the support needs in the education system are the keys to identifying the competencies required for planning an intervention.

Twenty five years after therapists in the USA were criticised for using an outdated medical model of support (Levangie, 1980), many therapists in South Africa are only just beginning to acknowledge the need to change to a social or educational model of support. As Royeen (1986, 1988) emphasises in relation to the therapists in the USA, the roles of the therapists need to be described within the education context, thus moving away from the language of the medical model. There is urgent need for professional and legislative guidelines in South Africa, as happened in the 1980s in the USA, which define the roles and responsibilities of the therapists who work in schools (American Occupational Therapy Association, 1987b). Clear guidelines indicating the relationship between education therapists and health therapists need to be developed in order to ensure that there is effective early intervention. This has been done in other countries, for example, in New Zealand (Ministry of Education New Zealand, 1999). Collaboration between health therapists and therapists from NGOs as well as private practitioners who have contact with young children prior to their entry into pre-school and school is needed. The role of school therapists helping ECD practitioners identifying barriers to learning needs to be explored.

The reluctance of therapists to shift to increased indirect support may be due to a number of factors which include: confidence in their ability to provide direct support; the request for direct support by teachers and parents; the fear that the learners will not be able to manage in school or at home without direct support; the concern that learners might develop complications, for example, contractures as a result of no direct therapy; the personal satisfaction of developing a close relationship with a specific learner over a long period of time with direct support; a lack of appropriate competencies for indirect support; fear of loss of professional identity; and the fear of change.

The importance of the roles of the Departments of Education and Health and the training institutions in facilitating the change in the role of the therapists cannot be underestimated. It is easier to blame the individual therapists, lowering their self-esteem, than to identify the broader systemic reasons for why they are finding it difficult to change their model of support. The structures need to be put in place to facilitate the development of the competencies that have been identified. As one therapist said in her letter to me after the last workshop:

> *So much of our support for learners in mainstream in this area is around accessing medical services, social services and appliances and if they had more contact with hospital physios/day hospital physios much of that direct support would not need to be done by therapists in Education Dept. On the other hand if they cannot access the above then how can one not give then this direct support as it impacts directly on their ability to learn. It seems for e.g. the 5 physios in the Urban EMDC couldn't be expected to give indirect support to all schools for staff with learners with physical needs without feeling horribly guilty about children who can't access direct support in some other way.*

The current roles and responsibilities of therapists have been identified in Chapter Five, and the overlap between disciplines is illustrated in Figure 5.26. The ability to provide this type of discipline-specific support is important. The competencies to perform these roles have been developed through traditional undergraduate training, in-service training, research and experience.

The ability to use a health promoting schools framework will depend on the leadership from school principals and the Department of Education. The Reference Group for Health Promoting Schools in the Western Cape has played a key leadership role in the development of health promoting schools, linking the health and education sectors. Links between the district-based support teams and the Reference Group need to be developed. The changes needed in the roles of the therapists are only one part of the much bigger change that is taking place in the education system. The implementation of a systemic, health promoting schools approach cannot be done by the therapists in isolation. It will need to be the approach taken by all in the district-based support team.

In summary, using the health promoting schools framework requires the reorientation of the therapy services to a systemic, health promoting approach, involving a shift from primarily direct support to primarily indirect support. However, the skills that are currently developed through direct support for learners are important. Thus, as far as is possible, the support to develop these skills needs to be integrated into the curriculum by giving support to the teachers through a collaborative partnership. Early intervention with very young children also needs to become a priority through collaboration between the Departments of Education and Health. The support for parents needs to start prior to entry into school with the relationship between therapists and parents developing as a partnership to empower the parents. The therapists support will be within the district-based support team, a multidisciplinary team that will support schools with identifying and addressing barriers to learning. Finally, while giving systemic support within the whole school development framework, I argue that the therapists, together with other members of the district-based support team need to use the five components of the health promoting approach for the support to be holistic and effective. The competencies that therapists need for this are presented in the Section 9.3.

9.3 COMPETENCIES NEEDED FOR EFFECTIVE SUPPORT

In this section of the chapter I synthesise the key findings and the relevant literature to answer my second research question: What competencies do therapists need to support schools in South Africa?

As has been explained, the shift from a medical model of support to a social or educational model of support requires different competencies. This is reflected in the international literature with recent emphasis being on support that facilitates learning, though there is acknowledgement that skills required for direct support will still be needed. The Department of Education (2003a) acknowledges that therapists require a high-level of clinical skills in addition to the broad range of competencies needed by the district-based support team. The ability to identify the specific competencies needed; to act upon this knowledge; and to implement the appropriate support is a key task of the district-based support team.

Following a reflection on my findings from therapists, teachers, parents I have identified the competencies that are essential for therapists to provide appropriate support to schools, as illustrated in Table 9.2. Where literature supports the identified competency this is indicated. There may need to be greater emphasis on certain competencies in different in districts when the needs of the particular community are considered and the principles of equity and of redress are taken into consideration (Department of Education, 2003a).

Table: 9.2: Competencies needed by therapists working in the school system

©: core competency
§ : specialised competency

Values	
	© All competencies need to be informed by: • a human rights value system • philosophical values of primary health care • philosophical values of inclusive education

Knowledge	
© 1. Knowledge and understanding of the concepts of primary health care and health promotion[6]	• The primary health care approach: equitable distribution of services and resources; community involvement; a focus on prevention and promotion rather than curative care; use of appropriate technology; and using a multisectoral approach • The underlying social, economic and political determinants of health that might lead to barriers to learning • Health promotion and the five components of the health promoting schools framework
§ 2. Knowledge of causes of illness, impairment and disability that occur before and after birth and their effects on the sensory, motor, psychosocial, and cognitive development[7]	
§ 3. Knowledge of major theories, treatment procedures, and research relevant to providing occupational therapy, physiotherapy and speech and language therapy for children (infants to 21 years of age)[8]	
© 4. Knowledge and understanding of the concepts of inclusive education and barriers to learning[9]	• The role of education support services in addressing barriers to learning* • The differences between the medical model of support, and the social or educational models of support* • The strategy for developing an inclusive education system through the development of inclusive and health promoting schools*

[6] Baum, 1998; Walt & Vaughan, 1981; Werner & Sanders, 1997; WHO, 1986, 1997
[7] American Occupational Therapy Association, 1989; Campbell, Van der Linden, & Palisano, 2000
[8] American Occupational Therapy Association, 1989; Campbell et al., 2000
[9] A. Bundy, personal communication, September 2004; Bundy, 1995; Department of Education, 1997, 2001, 2003a; Dunn, 1988

© 5. Knowledge of the relevant education legislation and associated guidelines[10] *	
© 6. Knowledge of the components and functions of the school system and support system within and outside the school; understanding of school culture[11] *	
© 7. Knowledge of the curriculum (RNCS) and expected outcomes for each level/grade[12] *	
© 8. Knowledge of the community	• Resources available and how to access them (education, health, welfare services, NGOs, community organisations) • Social differences; cultural differences; ways of parenting; and value systems of the community members
© 9. Knowledge of the process of change *	
Skills	
© 1. Ability to work within a health promoting schools framework[13] *	• identify if healthy policy needs to be developed in schools * • develop a safe and supportive school healthy environment * • build school-community networks and partnerships * • develop personal skills of learners, teachers and parents *

[10] A. Bundy, personal communication, September 2004; Department of Education, 1997, 2001, 2003a, 2003b

[11] Department of Education, 2003a, 2003b; Jirikowic et al., 2001

[12] Department of Education, 2002; Ogletree, Bull, Drew, & Lunnen, 2001; Santos, 2002

[13] Department of Education, 1997; Donald et al., 2002; Lazarus et al., 2000

2. Ability to use a systemic, health promoting approach to identifying barriers to learning, including barriers in the teaching approach, in the curriculum, in the environment, in the home, and in the community[14] *****	• © identify learners or educators who are "at risk" * • § perform holistic assessments on learners prior to entry into school and in the school environment, while supporting the teacher who has the major role in assessing learners and identifying barriers * • § assess the functional performance of individual learners within the school environment * • § select and administer appropriate assessment instruments and procedures taking into consideration the learner's age, developmental level, and impairment * • § interpret assessment results appropriately and use results to develop an intervention plan * • § identify the discrepancy between the learner's educational performance and the expectations of the teachers or others *
§ 3. Ability to address barriers to learning using direct support through the development, implementation, evaluation, and modification, as necessary, of an occupational therapy, physiotherapy or speech and language therapy programme[15]	• § identify what level of support is needed by specific learners * • § identify functional goals, related to educational outcomes, taking context into account * • § develop learners' skills, for example movement or communication skills • § address particular physical, social and psychological health problems of learners • § work with learners on a one-on-one basis; with small or large groups of learners; in the classroom, in another school environment or the home • § evaluate the outcome of the intervention/support • § make appropriate referrals

[14] Department of Education, 1997, 2001, 2003a; Donald et al., 2002; Lazarus et al., 2000
[15] Department of Education, 1997, 2001, 2003a; Giangreco, 1995; G. King et al., 1999

4. Ability to address barriers to learning using indirect support through developing and implementing healthy policy	© Advocate for the rights of learners and their families[16] * • to enable all children to attend school • supporting parents who want their children to go to ordinary schools • supporting parents if their children need access to support from therapists © Explain the implications of the inclusive education policy to teachers, parents, other sectors and the community * • on the various support roles of the therapists including direct and indirect support • on how to access support from therapists
5. Ability to address barriers to learning using indirect support through making appropriate changes to the school's physical and psychosocial environment[17]	© Physical environment • identify barriers in the physical environment and advocate for them to be addressed: architectural barriers; unsafe and inaccessible buildings; transportation barriers, inappropriate or inadequate classroom materials and equipment • facilitate teachers' awareness of the impact of the environment on learning § Assistive devices • identify need, provide and maintain assistive devices using appropriate technology • ensure that the assistive devices are used and maintained effectively by the parents and the teachers © Psychosocial environment * • identify barriers in the psychosocial environment • facilitate positive attitudes towards disability and diversity amongst the learners, teachers, parents and community members • provide emotional support

[16] Department of Education, 2003a; Jirikowic et al., 2001

[17] American Occupational Therapy Association, 1989; Bundy, 1995; Department of Education, 1997, 2001, 2003a; Glogowska, 1998; Glogowska & Campbell, 2000; Griswold, 1993; Law & Dunn, 1993; Levangie, 1980; McLaurin, 1984; Pollock & Stewart, 1998; Wren & Parkhouse, 1998

	• identify provide mentoring/counselling (including stress management) and develop the self-esteem of learners, teachers, colleagues in the district-based support team, and parents who are experiencing emotional difficulties • develop parent support groups
6. Ability to address barriers to learning using indirect support through the development of personal skills of parents, teachers, assistants, other professionals, student therapists, key workers, community members, and culturally and linguistically diverse learners[18]	§ Support teachers in adapting the curriculum (RNCS) or learning programme; assessment and evaluation of learners[19] * • facilitate a teacher-therapist curriculum discussion forum • develop individual and general learning programmes for use within the curriculum • develop materials for learners with particular learning needs including Braille or Sign Language • demonstrate specialised techniques to teachers: motivating learners; facilitating writing; developing learners' creativity to its full potential • identify resources inside and outside the school to provide support • endeavour to address the needs of teachers who are resistant to the implementation of inclusive education © Develop a collaborative partnership with the teachers, parents and others by[20]: • respecting teachers and parents' goals, including the particular skills children need at home and at school, before planning support interventions * • facilitating the empowerment of others including teachers, parents and the community members * § Use an adult education approach to develop the capacity to: • plan, present, facilitate and run groups or

[18] Bundy, 1995; Department of Education, 1997, 2003a; Jirikowic et al., 2001
[19] Department of Education, 1997, 2003a; Hirst & Britton, 1998
[20] Bundy, 1995; Connolly & Anderson, 1978; Greenwall, Heggarty & Woolard, 1998; Harn et al., 1999; Paradice & Adewusi, 2002; Santos, 2002; Wright & Kersner, 1998

	training workshops for parents, teachers or others * • supervise undergraduate therapy students * • monitor and evaluate the implementer's ability to learn the procedure * • motivate, guide and inspire the parents, teachers or others to use particular intervention strategies that they have been taught * © Network with parents, siblings, extended families, teachers, educational assistants, school governing bodies, community organisations, local businesses, and religious organisations, health sector, NGOs[21] * • facilitate the participation of parents in the school * • facilitate communication and links between teachers, parents and community organisations, including local business to facilitate work placement for learners * • develop the relationship between the special school/resource centre and the local community so local people use the school as a resource * • facilitate the involvement of the school in community development * • facilitate multidisciplinary and multisectoral collaboration/links and activities * • collaborate with health therapists, doctors at specialised clinics (for example, cerebral palsy clinic, genetics clinic or eye clinic) © Advocacy • become involved in advocacy campaigns in the community that promote inclusion * • inform communities of the rights of children * • facilitate community involvement in advocating for inclusive education * • facilitate community action to promote a positive attitude to children with disabilities and their integration into the community *

[21] Belmont & Verillon, 1999; Connolly & Anderson, 1978; Department of Education, 1997; McLaurin, 1984; Pollock & Stewart, 1998
[22] Department of Education, 2003a

	© Develop social inclusion programmes * § Implement screening as part of a preventive programme[22]
© 7. As part of a multidisciplinary, multifunctional district-based support team, to have the ability to reorient support provision using the health promoting schools framework[23]	• working within a whole-school development framework * • collaborating with others in the team * • participating in joint decision making in multidisciplinary meetings • actively including the parents in the team * • identifying barriers to learning, plan, make decisions, implement interventions and evaluate them as part of a team * • identifying which member of the team has most appropriate competencies for providing effective support while avoiding overlaps and gaps in the support service * • recognising and stating personal limitations * • reinforcing positive aspects of other members of the team without competing *
© 8. Ability to utilise appropriate management and organisational skills[24]	• documenting assessment and intervention outcomes accurately and appropriately, relating these to barriers to learning • providing organisational development support to schools to assist with the development of supportive and effective teaching and learning environments • using consultation skills; documentation skills; administration skills; leadership skills; delegation skills; co-ordination skills; time-keeping skills; problem-solving skills; referral skills; prioritising skills; creativity skills; fundraising skills • demonstrating specific technical skills including computer literacy and ability to drive a car
© 9. Ability to communicate effectively with teachers, parents, community members and	• demonstrating listening skills; writing skills; verbal skills; negotiating skills * • using the language of the parents and the learners, for example, Xhosa, Afrikaans,

[23] A. Bundy, personal communication, September 2004; Department of Education, 2003a; Giangreco, 1995
[24] American Occupational Therapy Association, 1989; Bundy, 1995; Clark & Miller, 1996; Department of Education, 2003a; Harn et al., 1999; Royeen, 1988

others, including multidisciplinary and multisectoral partners[25]	English, Sign Language, Alternative and augmentative communication methods, or Braille **or** an interpreter * • using appropriate terminology without sounding paternalistic or authoritarian * • describing the provision and benefits of direct and indirect therapy support *
© 10. Ability to take part in ongoing capacity development[26]	• participating in continuing professional development * • researching changes in therapy practice internationally and locally * • using an action-reflection approach to develop capacity *
© Attitudes	
	To develop an attitude that demonstrates[27] • a positive approach to the implementation of an inclusive education system and the shift to providing mainly indirect support • respect for the knowledge and skills of the teachers, parents, members of the district-based support team, and community members • belief in ability of the team to provide appropriate and effective support • a motivated, positive, assertive, yet flexible and creative attitude to work • inquisitiveness about new developments including professional developments • cultural competence: respecting the beliefs, language, interpersonal styles, and behaviours of others • understanding of parents' beliefs of causes of their children's disabilities • respect for diversity, acknowledging and celebrating differences • tolerance and being non-judgemental • empathy and sensitivity • a desire to work with other people

*** : not or seldom current taught in undergraduate training**

[25]Coutinho & Hunter, 1988
[26] Department of Education, 2003a
[27] Bundy, 1995; Department of Education, 1997, 2003a; Harn et al.; 1999 Jirkowic et al., 2001; New, 1998; Royeen, 1988

The list of specific (§) and core competencies (©) that are needed is long and may appear ambitious or daunting. However, my argument is that they are needed to provide effective support within a health promoting schools framework. Just as there is a plan by the Department of Education for the implementation of inclusive education over a period of 20 years, there needs to be an acknowledgement that it will take time for these competencies to develop and for all therapists in the schools to feel confident about providing indirect support. But effective support cannot wait another 20 years. While some competencies are currently taught in the training institutions, others are seldom taught (see asterisked competencies). The WCED has initiated training in an attempt to build the therapists' skills. I hope to continue collaborating with the WCED to develop training for the therapists based on the competencies that have been identified. An action-reflection approach would facilitate change while the therapists become empowered in the process. Multidisciplinary training of the district-based support team is also needed. The universities need to take a critical look at their current curricula and identify and address the gaps so that graduates who work with in schools are appropriately trained. This training will need a major restructuring of curricula at both undergraduate and postgraduate levels. The support of the professional bodies is needed.

As has been highlighted the major barriers to education for all children are socioeconomic in nature. These are the result of global and local political and economic factors. Health and education have been fundamentally affected by the global inequities and even if therapists develop all these competencies they cannot address all these barriers. This needs a far greater commitment to equity by the South African government.

9.4 CONCLUSIONS

In Chapter Nine I have discussed how the findings of the research have answered the research questions posed in Chapter One. Objective One to describe the current roles and responsibilities of therapists in the support system for schools in the Western Cape Province was met through the two surveys carried out in the Western Cape. I have discussed why the health promoting schools framework is an appropriate approach for

therapists to use to provide both direct and indirect support thus meeting Objective Two: To explore the future roles and responsibilities of therapists in terms of how they could provide support within the framework of the development of inclusive and health promoting schools. It is a strategy that can be used within the whole school development framework. The inclusive education system can be given effective systemic, health promoting support within this framework. If the health promoting schools framework is used by all in the district-based support teams, in collaboration with community members, it will be a powerful tool for change. The competencies that are needed by therapists were identified thus meeting Objective Three: To identify the competencies required by therapists to identify and address barriers to learning in schools. The WCED and the universities need to develop appropriate training to address the therapists' learning needs. The following chapter presents the conclusions and recommendations of the study.

CHAPTER TEN

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

This chapter presents a summary of the study; reflects on the strengths, weaknesses and limitations of the study; the implications for professional practice; the way forward; and finally recommendations and conclusions.

10.1 SUMMARY

The theme of the thesis was the changing roles of occupational therapists, physiotherapists, and speech and language therapists in education support services in South Africa. The study highlighted the competencies therapists require to provide appropriate support for an inclusive education system. The literature in Chapter Two and Three located the study within a human rights framework, but more specifically within a framework of inclusive education and health promoting schools. It indicated the importance of education support services for effective inclusive education and the need for these services to use a health promoting approach to service provision. This included a shift from a medical model of using mainly highly specialised direct support for a small group of learners to a health promotion model of indirect support for the education system including all learners, teachers and parents.

The aim of this research was to develop an appropriate and integrated approach for therapists to support schools within an inclusive and health promoting schools framework in South Africa.

Participatory action research, using quantitative and qualitative methodology, as described in Chapter Four, was used. This included a survey of all therapists in the Western Cape Province to determine which therapists were working with pre-school and school-aged learners and where. A second survey of all therapists working in special schools and a small number of private practitioners was undertaken to identify the roles of the therapists in providing direct and indirect support. In two of the seven education

districts, focus group discussions were held with teachers from special and ordinary schools, and parents of school-aged learners to identify the support they needed. In these two education districts workshops, incorporating focus groups, were held with the therapists to identify, firstly, the support they needed to give to learners, teachers, parents and the education system and, secondly, the competencies they needed to give this support. These findings were presented in Chapters Five to Eight.

The findings demonstrated that therapists had a very wide range of roles in providing direct support including: assessment, intervention with individual learners and learners in groups, and evaluation. Their interventions included the development of hearing, speech and communication skills; skills for activities of daily living; life skills; home management skills; work related skills; motor function skills; and play and leisure skills. At times therapists from different disciplines provided the same type of support. Indirect support included support for the schools system, teachers and parents. The study also revealed that multidisciplinary collaboration and teamwork were poorly developed.

Teachers involved in the study identified that they needed an enormous amount of support in fulfilling their crucial role in identifying barriers to learning; identifying the support learners needed; and addressing the barriers. This included support to teach a diverse group of learners; adapting content, presentation and evaluation of the curriculum; adapting the physical environment; accepting new roles of teachers and therapists; making changes to the school system; developing relationships with the parents; addressing challenges related to socio-economic problems; networking with the community; facilitating positive attitudes to diversity; developing supportive relationships with therapists; and further training.

Parents in this study indicated that they needed access to education and support for their children. This included direct support for their children; effective means of communicating with their children; knowledge and skills; emotional support; advocates to work with them in support of their children addressing environmental physical or

attitudinal barriers, and developing a supportive community; and supportive relationships with therapists.

Therapists identified the curriculum as the focus of their support for teachers. Support needs to become integrated into the curriculum and not additional to it. They highlighted the importance of their relationship with the teachers. Therapists emphasised the need to increase support for the parents. Unlike indirect support, they were confident in their abilities to provide effective direct support and wanted to continue to provide it. Therapists need support including further training in the competencies identified, and mentoring for their own well-being.

I have discussed how therapists can provide appropriate, holistic support services for schools, including the learners, teachers, other school personnel, parents and the community, within the district-based support team by using the health promoting schools framework. This would include developing healthy policies; promoting a healthy school environment; developing school-community partnerships; and personal skills development. This requires the re-orientation of the way therapists have traditionally provided support from mainly direct support to mainly indirect support. Therapists need to go beyond the medical and behavioural models of health promotion and use the framework of the socio-environmental model of health promotion.

I have identified the competencies therapists need to provide both direct and indirect support, using the health promoting schools framework, within the district-based support team. If therapists want to be an integral and effective part of education support services and implementation of an inclusive education system, they need to develop these competencies. In addition the system that trains them, including the universities, needs to ensure therapists have appropriate competencies through relevant undergraduate and postgraduate training. The professional bodies that evaluate and oversee the therapy qualifications need to ensure this happens. Implementation of inclusive education and the achievement of education for all is a dream worth striving for.

> The key to reducing barriers to learning within all education and training lies in a strengthened education support service. (Department of Education, 2001: 28)

10.2 REFLECTION ON STRENGTHS, WEAKNESSES AND LIMITATIONS OF THE RESEARCH

The research had several strengths. The purpose for using a participatory action research approach was its potential for bringing about change through the research process. It was identified as an appropriate approach to support the implementation of inclusive education. The use of this methodology has been a strength despite its limited use in the study.

Change resulting from the action-research could have been experienced by the therapists in two different ways that Morton-Cooper (2000) describes. Firstly, the research method could be described as a "professionalizing" approach with the purpose of changing and improving professional practice. Although the general purpose of the research was to facilitate the implementation of the policy of inclusive education, the more specific purpose was to help therapists change their model of providing support from mainly direct support to mainly indirect support using the health promoting schools framework. The use of workshops with the therapists has played a role in this.

As I reflect on the trustworthiness and reproducibility of my research, it is clear that using a health promoting schools framework for support is a practical alternative to a select group of learners, identified as having "special education needs", receiving direct support. Through listening to the needs of the teachers and parents and sharing these with the therapists they were able to identify the competencies they felt they needed in order to provide this support. I have synthesised these and other competencies identified in the literature within the health promoting schools framework. In the process which I followed, using the methods described by Strauss and Corbin (1998) and Denzin and Lincoln (1994), I collected rich data that was the outcome of my openness and willingness to listen and the participants willingness to share. I later became immersed in

this to identify the themes. I have tried not to force my own explanation on the data, but instead to share the world and experience of the participants. My relationships with therapists in the particular EMDCs included former colleagues with whom I had worked. This resulted in my gaining "inside" information about the concerns therapists experience and to me changing my approach at times to ensure the partnership was protected.

Is it possible to "speak for others"? Am I really trying to represent their views? I suspect I have filtered what I have heard, although I have reflected on it. Richardson (1994) says: "Self-reflexivity unmasks complex political/ideological agendas hidden in our writing. Truth claims are less easily validated now; desires to speak 'for' others are suspect" (Richardson, 1994: 523). Despite these questions, the research and the process of writing have been a journey of discovery for me. I have been given the opportunity to glimpse through a window into the concerns, the needs, the hopes and the vision of others. I have tried to make sense of this information in order to retell it accurately.

As action-research, it has been a critical, self-reflective, change-oriented process to achieve a positive social outcome as described by Bowling (2002), Miles and Huberman (1994), and Morton-Cooper (2000). As Morton-Cooper recommends, I hoped that using action research would be an empowering process for the therapists. Although the research may in the longer term be "empowering" as therapists are given a voice through my research which will be shared with the Department of Education, I do not know if it was an empowering experience for the therapists.

In my view, the gap in empowerment of the therapists is the main weakness of the research. Elden and Chisholm (1993) describe the importance of the process in participatory action research as being as important as the end product. How participatory was the research? As I reflect back I suggest that a stronger partnership with the therapists might have had different results, including giving therapists more confidence to move towards indirect support. However, this change needs to occur with the support of the rest of the district-based support team, the principals, the teachers and the parents. I

do not think a more participatory action research process would have led to different competencies being identified.

Secondly, at times I think the process verged on becoming "organisational" and top-down as I was keen for the new vision of an inclusive education system of the Education Department, and my own views on moving from direct to more indirect support, to be realised. I do recognise that there has been a difference between my agenda and that of the therapists who also need a lot of support. Also, apart from the implementation of the policy of inclusive education, completing the research has been an intrinsic part of my agenda. The therapists want some control over the process of change with the implementation of inclusive education and its effect on them.

Finally, I have maintained control over the process of the research. It has not been fully participatory with the therapists. I was always conscious of the requirements of the doctorate and meeting my objective. This is a weakness Morton-Cooper describes as not uncommon when using action research methodology in a doctorate.

Four limitations need to be mentioned. Firstly, the groups of parents and teachers who were involved in the study were not representative of all parents in the Western Cape. I have highlighted their particular needs which are the result of the particular context. As discussed in Chapter Four these findings cannot be generalised.

Secondly, the small number of private practitioners who responded made it difficult to identify any pattern of support provided by them or to accurately compare the findings with those of the WCED and school governing body therapists.

Thirdly, no clear distinction was made in the focus group discussions between the two ordinary schools that the WCED officials had identified as health promoting schools or actively involved in whole school development. Consequently it was not possible to determine if these schools had different support needs or were getting support from the Western Cape Reference Group for Health Promoting Schools or another source.

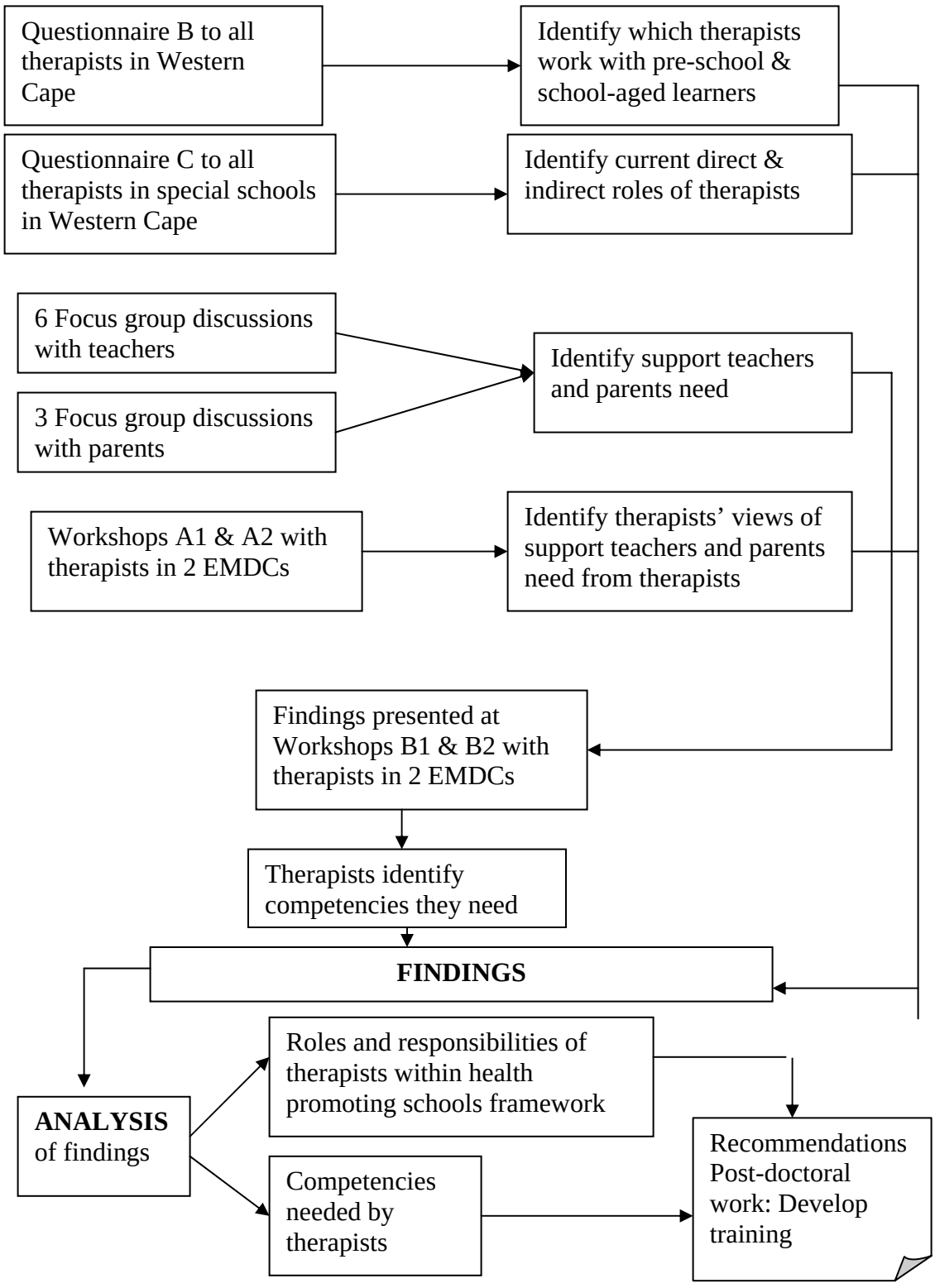
Fourthly, learners were not interviewed. The scope of this research has been limited and could not include this additional task. However, the views of the learners on the support they need, as well as the support they think the schools and parents need would be an important area for further research.

10.3 SIGNIFICANCE AND IMPLICATIONS FOR PROFESSIONAL PRACTICE

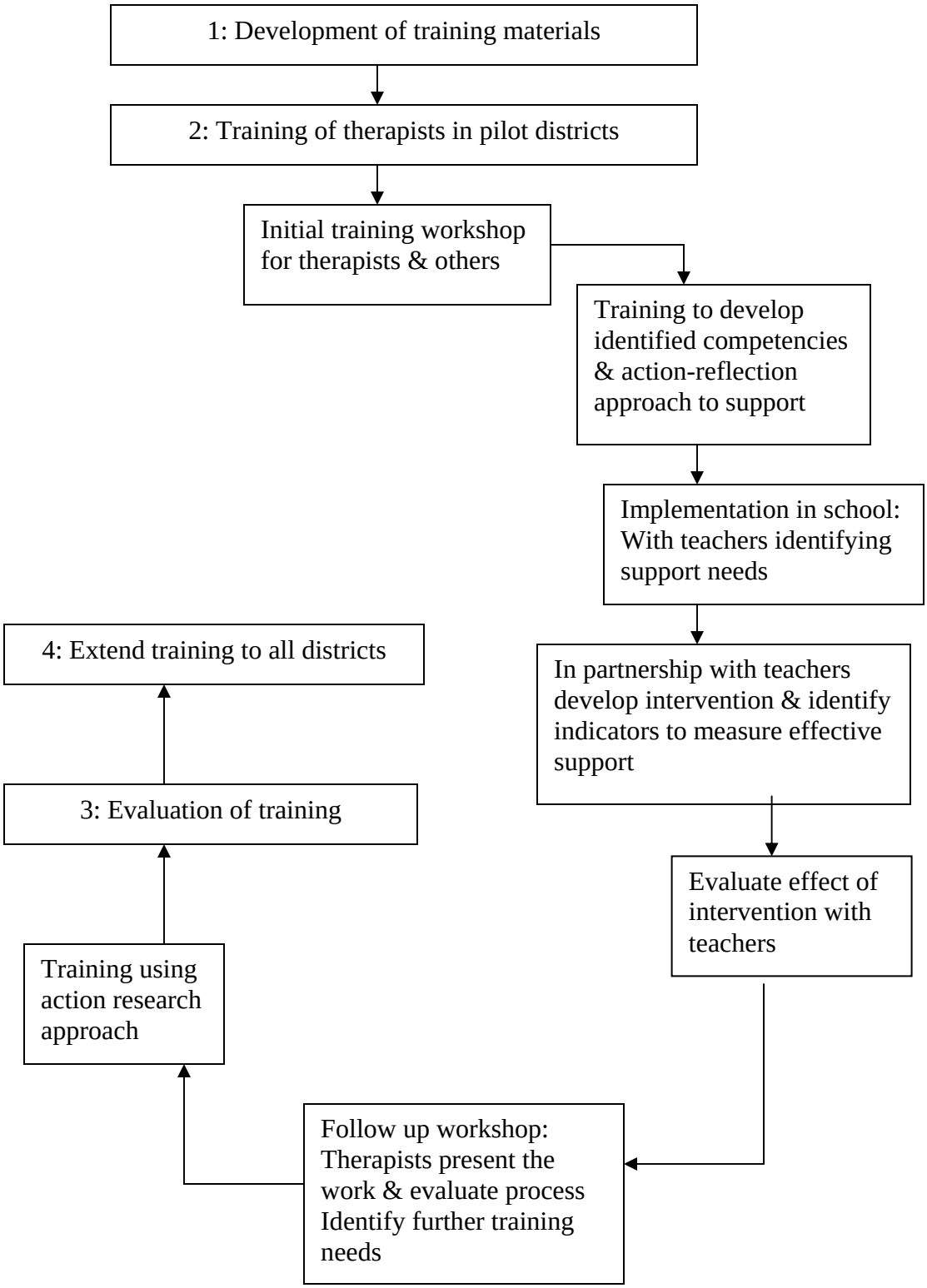
The research has focused on the change in the roles of therapists who work in schools in South Africa. The move from a highly specialised model of support for individual learners to a health promoting model of indirect support for the education system has major implications for therapists. The use of the health promoting schools approach as a framework for doing this has implications for the rest of the district-based support team, schools, the WCED and the national Department of Education. Developing appropriate training to enable this to happen has implications for all the institutions where therapists train.

In reflection I have asked: To what extent has there been a shift in the provision of support and the implementation of inclusive education over the period of the research? There has been increasing support for the policy articulated by the therapists. I have been told that in some special schools most support is indirect support but in better resourced special schools, particularly where there are therapists employed in governing body posts, the balance is still towards direct support. The WCED has suggested that in the future I undertake training of education support personnel with them. This is illustrated in Figure 4.1 Phase B. This will become the next phase of my participatory action research with the therapists. I am convinced that the idea of developing district-based support teams is essential. With this in mind I hope to include the school psychologists and school nurses as I, through the University of the Western Cape, undertake training in collaboration with the WCED, using an action-reflection approach.

Figure 4.1: Participatory action research design (From Chapter Four)
Phase A: This study: Identifying competencies needed by therapists



Phase B: Post-doctorate: Proposed training of therapists within the district-based support team



10.4 RECOMMENDATIONS

The recommendations that emerge from this study support the aim of the study which was to develop an appropriate and integrated approach for therapists to support schools within an inclusive and health promoting schools framework in South Africa. This involves implementation of inclusive education and the development of a systemic, health promoting approach to the provision of support by the therapists.

Recommendation 1

That the Department of Education acknowledge the health promoting schools framework as a practical, holistic, systemic approach to the provision of education support and incorporates it into the policy documents: "Conceptual and operational guidelines for the implementation of inclusive education: District-based support teams" (Department of Education, 2003a) and "Draft national strategy on screening, identification, assessment and support" (Department of Education, 2005).

Recommendation 2:

That there is a rapid development of the district-based support teams that includes integrating the therapists into these teams.

Recommendation 3

That there is time given for multidisciplinary training for all members of the district-based support team using the health promoting schools framework to develop the core and specialised competencies that have been identified.

Recommendation 4

That there is multidisciplinary training for teachers and the district-based support teams to facilitate the development of collaborative partnerships with mutual respect for one another's knowledge and skills.

Recommendation 5

That teachers, principals, parents and others in the community are informed about the implications of the paradigm shift in education support services to indirect support using a systemic health promoting approach to facilitate the removal of barriers to learning in the system.

Recommendation 6

That the training institutions provide appropriate undergraduate and postgraduate training to student therapists to develop the competencies that have been identified to facilitate the development of inclusive and health promoting schools.

Recommendation 7

That the professional bodies, the South African Occupational Therapy Association, South African Physiotherapy Society, South African Speech-Language-Hearing Association and Health Professional Council of South Africa ensure the training institutions integrate these competencies into the curricula.

Recommendation 8

That professional guidelines are developed by the Department of Education in collaboration with the professional bodies that define the roles and responsibilities of the therapists who work in schools.

Recommendation 9

That guidelines indicating the relationship between education therapists and health therapists are drawn up by the Departments of Education and Health to ensure co-ordinated access to therapy from birth and throughout school.

Recommendation 10

That financial resources are made available to the Department of Education to employ additional therapists in districts where large numbers of learners are experiencing barriers to learning, including those resulting from socio-economic factors.

10.5 CONCLUSIONS

The thesis was concerned with the implementation of the inclusive education system that has been introduced in South Africa to achieve the goal of education for all. The focus was on education support services and in particular occupational therapy, physiotherapy and speech and language therapy.

The development of an inclusive education system in South Africa will enable the vision of education for all in South Africa to become a reality. Despite many challenges for the education system, the development of health promoting schools in the Western Cape indicates that this approach is a framework schools can use as a strategy for whole school development.

The multidisciplinary district-based support team can provide the structure for effective support services to facilitate inclusion. The valuable, specialised support of therapists for the development of particular skills of learners including, for example, life skills, motor function skills, and communication skills needs, wherever possible, to be integrated into the curriculum. The shift in the balance of support from direct to indirect support will facilitate support for the teachers, non-teaching school personnel, the schools, as well as parents and community members.

The use of the health promoting schools framework for providing support will enable direct and indirect support to be integrated into support for the whole school system. This holistic support will facilitate access to the curriculum, within an environment that values inclusion. Through the development of particular competencies therapists will be able to provide support that facilitates the implementation of an inclusive education system.

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APPENDICES

TABLE OF CONTENTS

Appendix l: Questionnaire A

Questionnaire for therapists attending the workshop organized by the Western Cape Education Department, Paarl School, Cape Town, 3 April 2001.

Please can you answer the questions as fully as possible? I will use your names and addresses to contact you at a later stage in the study, when I will be sending out more detailed questionnaires and to plan and organise group discussions.
The personal information you provide will be treated with utmost confidentiality.

Name:……..

School/Place of work (and Address):……

……

……

Telephone:…… **Fax:**……

Occupation (tick): Occupational therapist
Physiotherapist
Speech and hearing therapist
Other (specify)

To assist me in designing a more detailed questionnaire, and to prepare for further interviews and discussions. Please can you describe the work you are currently (this year) doing?

1. At the school/centre with the children, parents and teachers:

2. With other children outside the school:

Do you have any other recommendations towards the development of the study?

Who else do you suggest I contact to get further information related to the role of therapists who work with children at school?

Trish Struthers, Physiotherapy Department, UWC, Private Bag X17, Bellville 7535. Tel: 9592542

Appendix ll: Questionnaire B

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY

October 2001

Dear occupational therapy, physiotherapy and speech & language therapy colleagues

Questionnaire: Research on Education Support Services

I am currently doing research related to the support that occupational therapists, physiotherapists and speech and language therapists give to school-aged learners in the Western Cape. This includes all aspects of the management and treatment of learners; support of the families of learners and the support of people who work with the learners such as teachers.

This questionnaire is being sent to all occupational therapists, physiotherapists and speech and language therapists in the Western Cape who were registered with the Health Professions Council of South Africa in 2000.

I would be most grateful if you would take a little of your valuable time to answer the questions. A stamped-addressed envelope is enclosed. All responses will be treated confidentially.

A workshop will be organised to give feedback to all interested therapists who work with school-aged learners in the Western Cape. If you have any queries about the study you can contact me by email at: pstruthers@uwc.ac.za

Thank you for taking the time to answer the questions.
Yours sincerely

Trish Struthers

The responses to these questions will be used to determine the proportion of therapists in the Western Cape who provide a service to school-aged learners in the Western Cape, and where that service is provided.

Your current employment

Please tick √ all relevant answers, you may need to tick more than one box for each question

I am qualified as:

• An occupational therapist	
• A physiotherapist	
• A speech and language therapist	

I work with preschool learners (aged 3-6 years)	Yes	No
I work with school-aged learners (ages 7-18)	Yes	No

a. I work in the state sector		
• In the Western Cape Education Department: WCED post	Yes	No
• School governing body post	Yes	No
Department of Health	Yes	No
Department of Social Development	Yes	No
Local authority	Yes	No
Other (please specify)	Yes	No

b. I work in private practice	Yes	No

c. I work for a non-governmental organisation (NGO) / welfare organisation	Yes	No

d. I teach at an academic institution	Yes	No

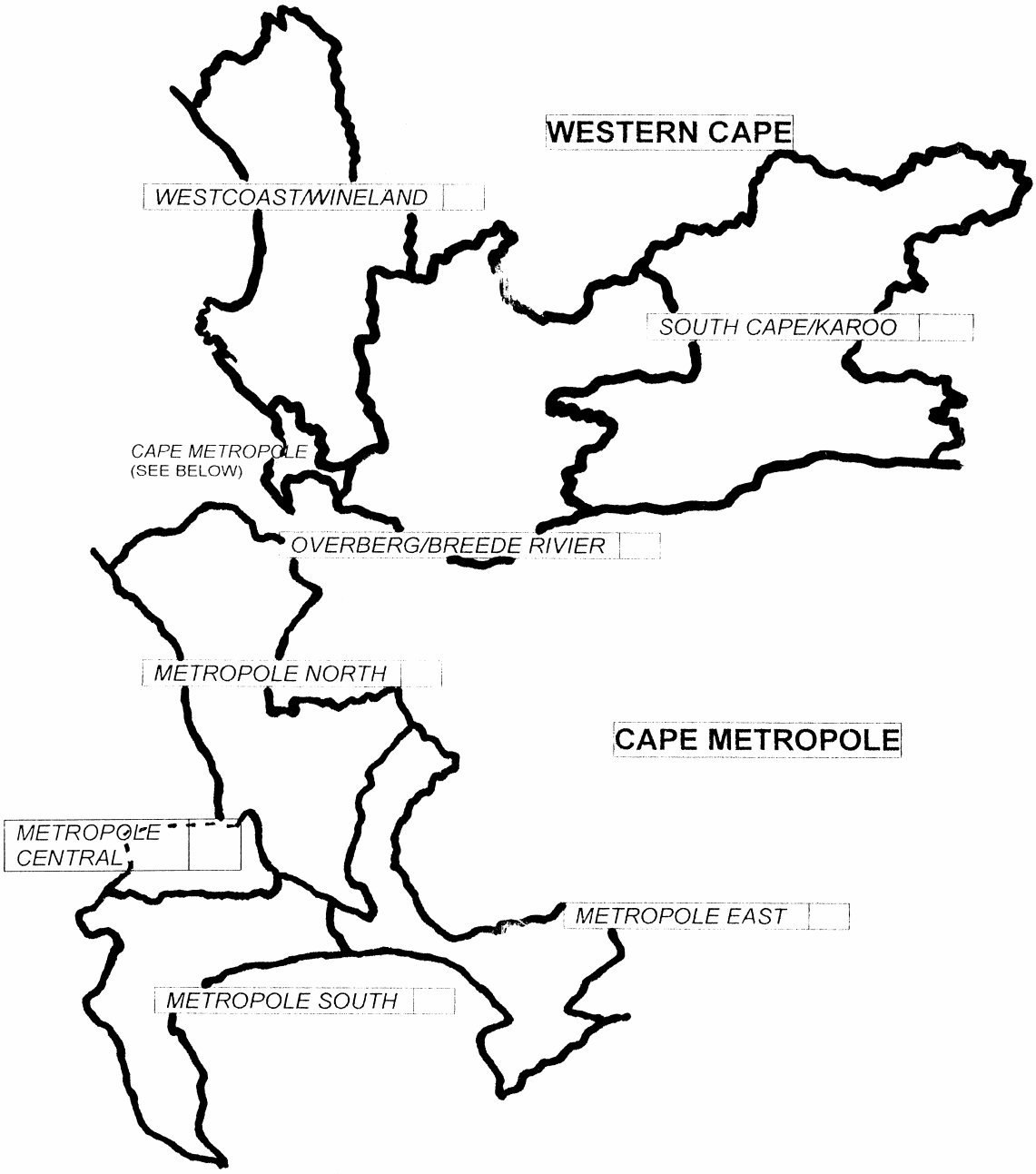
e. Other (please specify)

f. I am not currently working as an occupational therapist / physiotherapist / speech and language therapist	

Since July 2001, the Western Cape has been divided into seven education districts with a local management structure called the Education, Management and Development Centres (EMDCs) in each education district.
These areas are marked on the maps below.

Since July 2001, the Western Cape has been divided into seven education districts with a local management structure called the Education, Management and Development Centres (EMDCs) in each education district.
These areas are marked on the maps below.

On the map: Please indicate with an X in which area(s) you have worked with school-aged learners (during 2001).



Please tick √ all relevant answers, you may need to tick more than one box for each question

Where are you currently working with <u>pre-school learners</u> (aged 4-6 years)?

Give the approximate number of pre-school learners you treated/managed in 2001.

Place of work		Approx. number seen at this place
Education department: special preschool (may be part of special school/training centre)	Yes	
An ordinary preschool	Yes	
A special day care centre (managed by NGO/parents)	Yes	
Clinic run by NGO (e.g. Cerebral Palsy Association)	Yes	
At the learner's home	Yes	
A community health centre/day hospital	Yes	
A state hospital (inpatients and outpatients)	Yes	
A private practice (including private hospital)	Yes	
Other (please specify)	Yes	

Where are you currently working with <u>school-aged learners</u> (7-18 years)?

Give the approximate number of school-aged learners you treated/managed in 2001.

Place of work		Approx. number seen at this place
Education department: special school/training centre (excluding pre-school section)	Yes	
An ordinary school	Yes	
A special day care centre (managed by NGO/parents)	Yes	
At the learner's home	Yes	
A community health centre/day hospital	Yes	
A state hospital	Yes	
A private practice (including private hospital)	Yes	
Other (please specify)	Yes	

Many thanks for the time you have given to fill in this questionnaire

This section is optional:
I am planning to do further interviews and so may make further contact with you. Please can you supply the following details, which will be treated confidentially:
Name:
Address:
Telephone / Fax:
email:

Appendix lll: Questionnaire C

SECTION A

This section describes the support you give learners with disabilities or who experience barriers to learning. It is divided into 3 sub-sections:
A. Direct learner support
B. Indirect learner support
C. The support you would like to provide learners

Section A. Direct learner support
This section describes the support you give directly to individual learners or to groups of learners. (Including support given outside of official work time)

Please tick √ all relevant answers, you may need to tick more than one box for each question

Do you work directly with learners?	Yes	No

If yes please answer the rest of section A **If no** please go to section B, page 9

What do you assess learners for?

Hearing impairment	
Speech impairment	
Language delay/disorder	
Visual impairment	
Motor impairment	
Intellectual disability	
Learning disability	
Challenging behaviour	
Medical needs	
Other (please specify)	
I am not involved in assessing learners	

What is the reason you assess learners?

School readiness	
Admission to special school	
Treatment by therapist	
To advise the teacher	
To advise the parents	
Home programme	

Other (please specify)

Where do you work with learners?

Classroom	Often	Occasionally	Never
School therapy department	Often	Occasionally	Never
Alternative room / place in the school	Often	Occasionally	Never
School playground / sports grounds	Often	Occasionally	Never
Private practice	Often	Occasionally	Never
Learner's home	Often	Occasionally	Never

Other (please specify)

Do you work with learners?

Individually	Often	Occasionally	Never
In groups	Often	Occasionally	Never

What other professional personnel are providing education support services at your place of work? (Don't include teachers)

Occupational therapists	
Physiotherapists	
Speech and language therapists	
Psychologists	
School nurse	
Social worker	

Other (please specify)

Who do you include when you decide on the learner's support needs and your treatment goals?

The learner	Always	Sometimes	Never
The parents	Always	Sometimes	Never
The teacher	Always	Sometimes	Never
Occupational therapists	Always	Sometimes	Never
Physiotherapists	Always	Sometimes	Never
Speech and language therapists	Always	Sometimes	Never
Psychologists	Always	Sometimes	Never
School nurse	Always	Sometimes	Never
Social worker	Always	Sometimes	Never
No one else	Always	Sometimes	Never
Other (please specify)	Always	Sometimes	Never

What direct learner support have you, yourself, provided in 2001? (Exclude referrals)

Hearing/speech/communication skills

Hearing tests	
Auditory perceptual skills	
Language and speech skills	
Sign language	
Oral-motor exercises / therapy	
Alternative and augmentative communication systems	
Functional communication (using equipment: telephone, computer, Braille writer)	
Reading and spelling remediation	
Visual perception skills	

Other (please specify)

Activities of daily living / Self-maintenance tasks

Oral hygiene	
Grooming (skin, ears, eyes, hair care/cosmetic use)	
Bathing/showering	
Toilet hygiene (clothing, position, cleaning, transfers)	
Personal device care (cleaning and maintaining hearing aids, prosthetics, adaptive equipment etc)	

Dressing (appropriate selection, fastening, removing etc)	
Feeding and eating (selecting, use of utensils, sucking, swallowing, alternative methods)	
Taking medication (open/close container, following prescribed schedule)	

Other (please specify)

Life skills / Social skills

Health maintenance (decrease risk behaviours)	
Socialisation	
Community mobility (use of car, bus, taxi, train etc)	
Emergency response to hazardous situations	
Sexual expression (engaging in desired sexual/intimate activities)	

Other (please specify)

Home management

Clothing care (obtaining, laundering, ironing, mending etc)	
Cleaning the home	
Meal preparation and cleanup	
Shopping	
Money management	

Other (please specify)

Work and productive activities: Educational activities

Vocational exploration (determine aptitude, skills and interest development)	
Work performance preparation / vocational training	
Work acquisition / placement (identify work opportunity, complete application, interview process)	

Other (please specify)

Motor function activities

Fine motor functional activities	
Gross motor functional activities	
Motor co-ordination activities	
Posture correction	
Seating positioning in classroom	
Alternative positioning in school (standing, lying)	

Other (please specify)

Play or leisure activities

Play exploration (identify opportunities, interests, appropriate activities etc)	
Play performance	
Prevention of sports injuries	
Treatment of sports injuries	
Sport for disabled learners (organisation, training etc)	
Hydrotherapy	
Horse riding	
Dance therapy	
Extra-mural activities (e.g. choir)	

Other (please specify)

Counselling

Are you involved in formal counselling of learners?	Yes	No

Do you evaluate your direct support/treatment?	Always	Sometimes	Never

If always or sometimes:

I use regular assessment procedures	
I assess whether the goal was achieved within the proposed timeframe	

If sometimes or never:

Measurable goals are not set with all learners	
Some goals are very difficult to evaluate (e.g. very broad; vague)	
There is insufficient time available to evaluate	

Other (please specify)

Who do you include when you evaluate your direct support/treatment?

The learner	Always	Sometimes	Never
The parents	Always	Sometimes	Never
The teacher	Always	Sometimes	Never
Occupational therapists	Always	Sometimes	Never
Physiotherapists	Always	Sometimes	Never
Speech and language therapists	Always	Sometimes	Never
Psychologists	Always	Sometimes	Never
School nurse	Always	Sometimes	Never
Social worker	Always	Sometimes	Never
No one else	Always	Sometimes	Never
Other (please specify)	Always	Sometimes	Never

Do you refer learners to therapists outside the school for direct support/treatment?	Yes	No

If your answer is **yes**:
Which other therapists do you refer learners to?

Therapists based in state hospitals

Occupational therapists	
Physiotherapists	
Speech and language therapists	

Private practitioners

Occupational therapists	
Physiotherapists	
Speech and language therapists	

If your answer is **no**:
Why not?

The learners get acceptable support from the therapists in the school	
The families cannot afford the cost	
There are no private practitioners available	

Other (please specify)

SECTION B

Section B. Indirect learner support

This section describes the support you give learners with disabilities or who experience barriers to learning, through your work with teachers; parents or others; and developing a supportive environment.
(Including support given outside of official work time)

a. Support provided to teachers by therapists

Please tick √ all relevant answers, you may need to tick more than one box for each question

Do you give support to teachers?

	Individually			In groups		
Teachers in special schools	Often	Sometimes	Never	Often	Sometimes	Never
Teachers in ordinary schools	Often	Sometimes	Never	Often	Sometimes	Never
Teacher support teams at schools	Often	Sometimes	Never	Often	Sometimes	Never
Teachers at the EMDC/(school clinic)	Often	Sometimes	Never	Often	Sometimes	Never

What support do you provide teachers?
Curriculum support

Information on how to adapt the curriculum	
Information on disability	
Information on learner's surgery	
Advice on language development	
Advice on behaviour management strategies	
Advice on hearing aid maintenance	
Advice on alternative and augmentative communication systems	
Advice on care of mobility assistive devices (wheelchair, crutches, orthotics)	
Advice on adapting and promoting physical activity to include all learners	
Advice on feeding techniques	
Design specific programmes for teachers to use with individual learners	
Monitoring of support given to the learners by the teachers	
Provide equipment for the teacher's use	
Provide written reports on learners for teachers	
Provide information on what support therapists offer	

Ergonomics and kinetic handling

Advice on seating for learners	
Advice on adapted standing positions for learners	
Lifting techniques and advice on back care for teacher	

Advocacy

Advocacy with teachers to accept learners from special schools	
Provide information on organisations for people with disabilities	
Provide information on the rights of people with disabilities	

Other (please specify)

Who else in the school do you provide training to?

Classroom assistants	Yes	No	Not employed in school
Hostel personnel	Yes	No	Not employed in school
Bus drivers	Yes	No	Not employed in school
Administration personnel	Yes	No	Not employed in school

Others (please specify)

b. Support that therapists provide to parents of learners with disabilities or who experience barriers to learning

Please tick √ all relevant answers, you may need to tick more than one box for each question

Which statements best describe your relationship with the parents of learners you work with?

I have regular contact with most of the parents	Ordinary schools	Special schools
I have regular contact with some parents	Ordinary schools	Special schools
I have regular contact with only a few parents	Ordinary schools	Special schools
I meet the parents when I first assess the learners, but seldom after that	Ordinary schools	Special schools
There are some parents who I have never met	Ordinary schools	Special schools
There are many parents who I have never met	Ordinary schools	Special schools
I have never met any of the parents	Ordinary schools	Special schools
I do not work with learners attending these schools	Ordinary schools	Special schools

What support do you provide parents?

Development of parents' knowledge and skills

Information on disability	
Information on surgery	
Advice on behaviour management strategies	
Advice on language development	
Advice on hearing aid and FM maintenance	
Advice on alternative and augmentative communication systems	
Advice on care of mobility assistive devices (wheelchair, crutches, orthotics)	
Advice on feeding techniques	
Advice on seating and standing positions at home	
Advice on lifting techniques and back care for parents	
Involve parents in choosing assistive devices	
Regular reports on the learner's progress in therapy	

Other (please specify)

Support in the home

Home visits	
Provide parent with home programmes	
Provide advice on home adaptations	
Liaise with doctor (on behalf of parents)	
Transport learners to hospital appointments (on behalf of parents)	

Other (please specify)

Advocacy

Advocacy with parents to accept children in school	
Provide information on organisations for people with disabilities	
Provide information on the rights of people with disabilities	
Other (please specify)	

Emotional support

Formal counselling for parents	

c. Therapists support for the general learner population

Please tick √ all relevant answers, you may need to tick more than one box for each question

Support for learners in ordinary schools

Provision of information on disability	Yes	No
Provision of information on the rights of people with disabilities	Yes	No
Provision of information on inclusion	Yes	No
Are you involved with learners from ordinary schools visiting the therapy department at a special school?	Yes	No

Other (please specify)

d. Therapists' involvement in developing a supportive environment

Please tick √ all relevant answers, you may need to tick more than one box for each question

Indicate what adaptations to the school environment you have organised:

Ramps	
Rails	
Adaptations to toilets & basins	
Adaptations in school classroom	
Adaptations to school playground	

Other (please specify)

Indicate which aspects of management you are involved with:

Administration/record keeping related to support of learners for therapy department	
Influencing decisions on policy	
Multidisciplinary team meetings with other therapists	
Multidisciplinary team meetings including teachers	
Meetings with EMDC/school clinic	
Meetings with NGO / welfare organisations	
Member of school governing body	
Member of school committee/s	
Organising/participating in fundraising activities for special school	
Organising/participating in fundraising activities for assistive devices (e.g. wheelchairs)	

Other (please specify)

e. Therapists' support of the curriculum

Please tick √ all relevant answers, you may need to tick more than one box for each question

A flexible curriculum enables learners to participate in the leaning process.

Indicate how you have been involved with curriculum development

Adaptation of the curriculum content	Yes	No
Developing alternative ways of presenting the curriculum	Yes	No
Developing alternative ways of evaluation/assessment of the learners	Yes	No

Other (please specify)

Appropriate assistive devices facilitate the removal of barriers by enabling learners to access the curriculum and functional independence

Which assistive devices do you provide?

Hearing aids (recommendation, fitting and evaluation)	
Walking aids (crutches, rollator, walking sticks)	
Manual wheelchairs	
Electric wheelchairs	
Special seating	
Support for standing	
Aids for communication	
Aids for writing (e.g. computer)	
Aids for dressing	
Aids for feeding	

Other (please specify)

Which assistive devices do you make?

Ear moulds	
Arm / hand splints	
Legs / foot splints	
Special seating	
Special standing support	

Other (please specify)

What is your role in the maintenance and repair of assistive devices?

I maintain the assistive devices	
I repair the assistive devices	
I teach the learners to do some of the maintenance and repair	
I involve the parents in some of the maintenance and repair	
I organise for the repairs to be done by someone else	
I do not have any role in the maintenance and repair	

f. Community support

Are you developing the therapy department as a resource center for the community?	Yes	No

Indicate the other support you provide the community:

Information

Information on disability	
Information on the rights of children with disabilities	
Information on disabled peoples organisations	
Information on organisations that provide assistance for children with disabilities	
Information the early identification of problems	

Other (please specify)

Training

Training of community based workers	
Training of volunteers to assist in the school	

Other (please specify)

Approach used in community

Open days at special school for the community	
Talks in community	
Workshops in community	

Other (please specify)

Advocacy

Do you participate in local campaign(s) (e.g. access to transport / inclusion in community facilities)	

Other (please specify)

Industry

Do you have links with workplaces/industry?	Yes	No

In relation to your support for learners with disabilities and learners who experience barriers to learning, which community organisations and disabled people's organisations have you had contact with over the past year?

South African Federal Council on Disability	
Disabled People of South Africa (DPSA)	
Disabled Children's Action Group (DICAG)	
Western Cape Forum for Intellectual Disability	
Western Cape Inclusive Education Forum	
St Giles: Sports for the disabled	
Cerebral Palsy Association	
SACLA	
Interface	

Others

C. This section describes the support you would like to provide learners:

Using the information that you have provided to the above questions, estimate the % of time you have spent on the different areas of support during 2001:
(Include the time providing support outside of official work time)

Type of support given	% of time
A. Direct support service for the learner	
B. Indirect support service	
with the teachers	
with the parents	
with the general learners in ordinary schools	
changing the environment (physical and mangement)	
supporting the curriculum (including providing assistive devices)	
in the community	
Total	100

Please reflect on the time you spend on the different categories. Would you like to be allocating your time any differently?

Yes	No

If your answer is YES: What % of your time do you wish you could spend on:

Type of support given	% of time
A. Direct support service for the learner	
B. Indirect support service	
with the teachers	
with the parents	
with the general learners in ordinary schools	
changing the environment (physical and mangement)	
supporting the curriculum (including providing assistive devices)	
in the community	
Total	100

SECTION C Capacity development

Capacity development includes various ways to develop yourself in your job.
It includes the training, professional development, support and mentoring you are given.

Indicate how your own capacity has been developed over the past year

Through training

In-service training at your workplace by other workplace therapists	
In-service training organised by WCED	
Short courses by specialised therapists	
Short courses organised by your professional association	
Short courses organised by a university	
Post graduate degree	
I have not had any formal training in the past year	

Other (please specify)

Supervision

By your head of department	
By the school principal	

Other (please specify)

Support / Mentoring

From colleagues in same profession	
From colleagues in other therapy profession	
From head of department	
From teachers	
From the principal	

Other (please specify)

Indicate your role in the development of the capacity of others

Training

Teaching / training of student therapists in ordinary schools	
Teaching / training of student therapists in special schools	
Medical students – observation of your work	
Nursing students – observation of your work	
Student teachers – observation of your work	

Other (please specify)

Support / Mentoring

Mentoring / support of student therapists in ordinary schools	
Mentoring / support of student therapists in special schools	

Other (please specify)

Supervision

Supervision of student therapists in ordinary schools	
Supervision of student therapists in special schools	

Other (please specify)

Many thanks for the time you have given to fill in this questionnaire.

This section optional:
I am planning to do further interviews and so may make further contact with you. Please can you supply the following details, which will be treated confidentially:

Name:

Place of work:

Address (either work or home):

Telephone / Fax:

email:

Appendix lV: Interview guide to use with parents

Focus Group Discussion with parents of learners at special schools

Questions

1. Information about your child
    - Would you tell us briefly about your child?
    - Can you tell us about his or her time at the school.

2. Support for your child
    - Do you know what the occupational therapists, physiotherapists and speech therapists have done with your child?
    - Can you tell me about any experiences that your child has had with occupational therapists, physiotherapists and speech therapists in the school?
    - In what ways have the experiences helped your child?
    - What things were difficult?

3. Support for parents

    - What kind of help did you as the parent get from the therapists in the past?
    - Are there things that you would like to have had more information about?
    - That would you like the therapists to have understood that they didn't seem to understand?
    - Was there any advice that you found useful or may have needed to help at home?
    - Do you think the therapists understood the difficulties that you had in the community having a child with a disability? How did they help with helping your child be included in the community?

4. Support for the link with the community
    - In what ways do you think it would be useful for therapists to have links with community organisations?
    - Which community organizations are there in your community that you would like the therapists to have links with?

5. Support for the teacher
    - How do you think the therapist can help your child's teacher so your child can learn more easily?

Appendix V: Interview guide to use with teachers

Focus Group Discussion with teachers at ordinary schools

1. Information about the school
   - We don't know much about your school and would like to learn more.
   - Would you tell us briefly about your school setup?

2. Support for the learners
   - In any class there are always some learners who find it difficult to follow the ordinary curriculum.
   - Please will you describe the kind of difficulties that the learners experience?
   - Sometimes learners or teachers experience problems related to their posture either because of the way they sit or the way they walk.
   - Other learners experience problems related to communication, in what ways do you think therapists could help?
   - Can you tell me about any experiences that you have had with occupational therapists, physiotherapists and speech therapists working with the learners in your class or in the school?

3. Support for teachers
In special schools there are occupational therapists, physiotherapists and speech therapists who work with the teachers.
   - Can you tell me about the advice or help with the learners these therapists have given to you?
   - What kind of help you think you would like to get from the therapists?

4. Support for the parents
   - Can you talk about the kind of support that you think the parents need.

5. Support for the school system
   - I'd like to hear your ideas on how therapists could be involved in other aspects of your school apart from in the classroom.

Sometimes therapists give advice on the environment, for example changes to the playground or putting in ramps or rails if they are needed in the school to make it easier for learners and teachers.
   - In what way do you think therapists could help in changing the environment in your school?
   - What kind of contribution do you think therapists could make to your school governing body?
   - Many schools have been busy developing new policy guidelines e.g. a policy on child abuse or a policy on HIV/AIDS. In what ways would you like therapists to become involved in developing your school policy?

6. Support for the link with the community
   - In what ways do you think it would be useful for therapists to have links with community organisations?

7. Health promoting school
   - In what ways do you think that being a health promoting school has been a support to the learners?
   - How do you think therapists could play a role in the whole school development or the development of health promoting schools?

Appendix VI: Training unit for Therapist Workshop

Training and Development Programme for Education Therapists

Draft 1

Fiona Lewis and Patricia Struthers

Western Cape Education Department
&
University of the Western Cape

October 2003

Unit 1:

Integration of therapeutic tools within the curriculum

Learning Outcomes for Unit 1:

By the end of this unit, you should be able to:

- Identify the skills needed to provide effective support to educators
- Identify indicators for measuring the effectiveness of the support provided
- Demonstrate an understanding of the nature of barriers to learning experienced by learners, in particular within the curriculum and the school
- Understand the difference between engaging with and achievement of learning outcomes (in other words, what do learning outcomes mean?)
- Understand the relationship between objectives (project planning) and learning outcomes (curriculum planning)
- Understand the relationship between indicators (project planning) and assessment standards (curriculum planning)
- Understand how to integrate therapeutic activities and tools into learning programmes/lesson plans
- Use aspects of project planning and action-based research to develop and evaluate an integrated learning programme/lesson plan (curriculum planning) in collaboration with the educator
- Identify the role and the relationship of the education therapist to the educator in the planning, development and evaluation of learning programmes/lesson plans

Welcome to Unit 1

Both outcomes-based education (the RNCS [1]) and the policy of inclusive education (WP6[2]) provide the foundation for developing strategies for teaching and developing the minds and bodies of young learners in South Africa. They strive to enable all learners to achieve to their maximum ability. All educators, education therapists, education managers etc are key contributors to the transformation of education in South Africa.

A question asked in **Teach Us Too** by Laetitia Brümmer that is important here is as follows:

[1] RNCS - Revised National Curriculum Statements (2005)
[2] WP6 - White Paper no 6 on Building an Inclusive Education and Training System

> How are we going to teach the children? This question is answered with the following: "more important than any method, is the teacher's (therapist's) attitude, her willingness to work, and the love and acceptance that she is willing to give the learners. In training teachers, one must be careful not to break down good teaching methods, and leave teachers with instructions that they do not understand or like."

Unit 1 explores the way you can give learners support to facilitate their ability to gain access to the curriculum. It differentiates between direct 'hands-on' support for the learner and indirect support for the learner through the support for educator. It will give you the opportunity to put the theory of providing support to educators into practice through the use of a project planning cycle.

There are five sections to this unit;
Section One: Identifying support needs in practice
Section Two: Developing an integrated therapy/learning programme
Section Three: Implementing the action-based programme
Section Four: Evaluating the action-based programme and the training support
Section Five: Touching on the educator-therapist relationship

In Section One, you will discuss and determine the support needs for educators, therapists and learners in managing a variety of barriers to learning. This will clarify why there is a need to integrate the use of therapeutic tools, activities and techniques within the curriculum.

In Section Two, you will engage actively in a project planning process in order to both identify the roles of the therapist and educator in curriculum planning and to develop an action-based integrated therapy/learning programme.

In Section Three, you will put this programme into practice in the classroom.

Section Four will then involve an evaluation both of the success of the programme in meeting it's objectives (using the indicators decided upon in the planning and development stage), and the success of the training programme, against the learning outcomes specified at the beginning of this chapter.

Finally, Section Five will touch on the dynamics in the relationship between the therapist and the educator, and how this impacts on the learner in the classroom.

Keys:

 = Discussion point/exercise

= Writing: activity linked to reading or writing

= Content input

= Reading to be done during the course of the programme

Ice-Breaker One:
Pair up with a partner, preferably someone you don't yet know well.
Face one another directly, and using only gesture, signs, actions etc introduce yourself to your partner. While your partner is introducing him/herself to you, write down what your partner has said and how she/he said it. Remember, at the end of the exercise you are going to have to introduce your partner to the group.

When doing the introductions to the group, you will introduce your partner using the signs and symbols used by the partner, but explaining these verbally to the group. At the end of the introduction, your partner can then make any corrections, additions or deletions, depending on how well you succeeded in the introduction.

Now, let's move onto the work.....

Section One: Identifying support needs in practice

In Section One, you will discuss and determine the support needs for educators, therapists and learners in managing a variety of barriers to learning. This will clarify why there is a need to integrate the use of therapeutic tools, activities and techniques within the curriculum.

Direct support:
Traditionally education therapists have provided support directly to learners on a one-on-one basis or with small groups of learners. Individual learners, usually learners with disabilities, were identified as having 'special needs'. Frequently these learners were withdrawn from the classroom for treatment by educational therapists.

Indirect support:
An alternative model of support that is being used extensively internationally and is being promoted by the Department of Education is for therapists to focus on indirect support for learners. The focus here is not on changing individual learners but on changing the system or the environment that the education is taking place in to enable the learner to learn. Many of the barriers to learning that learners experience, are extrinsic and not intrinsically within the learner.

Reading 1: Bundy, A. C., Assessment and intervention in school-based practice: Answering questions and minimizing discrepancies. *Physical & Occupational Therapy in Paediatrics*. Vol. 15, No. 2, 1995, pp 69-88.
Reading 2: Swinth, Y & Hanft, N., School-based practice: Moving Beyond 1:1 Service delivery. In OT Practise, September 16, 2002, pp - 12 - 20

TASK: Group discussion - To determine the skills and knowledge you need to provide effective indirect support to learners by providing support to the educator.

Questions:

1. What support do you think educators need from therapists?
   - Do you have the knowledge and skills to do this?
   - What are the gaps in the skills that you have and those you have identified?
2. How do you think you can measure effective indirect support for the learner?

Barriers to learning identified by the White Paper 6:

TASK: In a small group, using the following situations/scenario, list the barriers to learning that educators may encounter that will impact on learners:

- ***A day in the life of the classroom…. Thandi's story***

"Thandi is a fourteen-year-old girl who is one of 48 other students in Grade 6 in a primary school in the rural part of Mpumalanga. She started school eight years ago, and had to repeat both of the first two years, she was then promoted on age through to grade 6.
Her teacher reports that, despite her age and the fact that she is repeating, she is not sure that Thandi can pass this year. Although she can read slowly in Ndebele (her home language) her understanding of what she is reading is not very good. Her writing is neat and she can copy accurately but she finds it very difficult to make up her own sentences. If she has learned something over and over, she remembers it reasonably well.

However, she struggles with any king of problem-solving, or to answer questions that require more than rote memory. Although the teacher is aware of these difficulties, she does not know what to do to help her. With 48 other students in the class, Thandi just has to keep up as best she can. Support services are difficult to access and there is no-one in the school to help or give advice on difficulties such as this. Anyway, neither the teacher nor the school as a whole see students like Thandi as 'problems'. There are many others like her. The 'real problems' are seen to be the disruptive students.

Anthough there are some other solder students in the class whom she finds more difficult to handle, the teacher says that she likes having Thandi in her class. She is obedient and wants to be helpful. She is often given things to do, like 'taking messages to the principal or sweeping up the classroom'. Although she can be quite 'bossy' with the younger students, they accept her almost like an older sister so that she has her plase in the social life of the class. Thandi is also physically strong. Although she has never won a race, she enjoys school athletics.

Reading: Department of Education (2001, July). *Education White Paper 6: Special needs education: Building an inclusive education and training system.* Pretoria: Education Department,

- Problems in the organisation and governance of the schooling system
- Socio-economic factors including a lack of access to basic services
- Poverty and underdevelopment
- Factors which place learners at risk
- Negative attitudes towards difference resulting in discrimination and prejudice
- Inappropriate assessment of need
- An inflexible curriculum
- An inaccessible and unsafe learning environment
- Discrimination related to language and communication
- Inadequate and inequitable funding to overcome barriers
- Inappropriate and inadequate provision of support services
- A lack of parental recognition and involvement
- Inadequate human resource development strategies

Inflexible curriculum

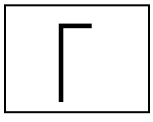
An inflexible curriculum has been identified as a barrier to learning. This Unit explores your role in supporting the educator to make the curriculum accessible to the learners.

Section Two: Developing an integrated therapy/learning programme

In section two, you will engage actively in a project planning process in order to both identify the roles of the therapist and educator in curriculum planning and to develop an action-based integrated therapy/learning programme.

In section one, we identified that an inflexible curriculum is a barrier to learning. As education therapists, we have a valuable role to play in creating a classroom environment and a teaching and learning programme that enable learners to access the curriculum. What does this actually mean though? This section will take you through the process of looking at four specific questions related to your interaction with the curriculum, translating these into SMART objectives, and then by looking at specific therapeutic tools (such as a motor development programme), develop an integrated learning/therapy programme.

Reading: Department of Education (2002). Revised National Curriculum Statement Grades r -9 (Schools) POLICY Overview, pp 8 - 19.
Specific sections to refer to include the following highlights: The kind of learner that is envisaged; The kind of teacher that is envisaged; Principles of the RNCS; What is a learning outcome? What is an assessment standard? How different is an assessment standard from a learning outcome?



Project planning:

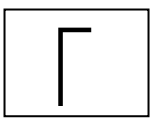
Life Orientation Learning Outcomes:

Learning outcome 1: Health Promotion
The learner will be able to make informed decisions regarding personal, community and environmental health.
The learner in the FoundationPhase is exposed to communicable childhood diseases. Therefore the learner should have knowledge of these diseases, as well as of HIV/AIDS. At this age, the learner is vulnerable to abuse. Safety measures particularly relevant to the learner in this Phase should be addressed.

Learning Outcome 2: Social Development
The learner will be able to demonstrate an understanding of and commitment to constitutional rights and responsibilities, and to show an understanding of diverse cultures and religions.
The Foundation Phase learner should know and exercise rights and responsibilities as guaranteed in the South African Constitution. The learner should be encouraged to recognize and oppose unfair discrimination. Socialisation should include forming strong and healthy relationships with family, friends, school and local communities. Knowledge of diverse religions will contribute to non-discriminatory attitudes to counter and prevent prejudices.

Learning Outcome 3: Personal Development
The learner will be able to use acquired lifeskills to achieve and extend personal potential to respond effectively to challenges in his/her world.
The self-concept of the Foundation Phase learner is at an early stage of development. The learner already has some attitudes and feelings regarding personal worth; these are dependent on the learners' experiences. It is important to give the learner opportunities for positive self-concept formation, as well as to explore and express feelings. The learner needs to be assisted to adjust to the learning environment.

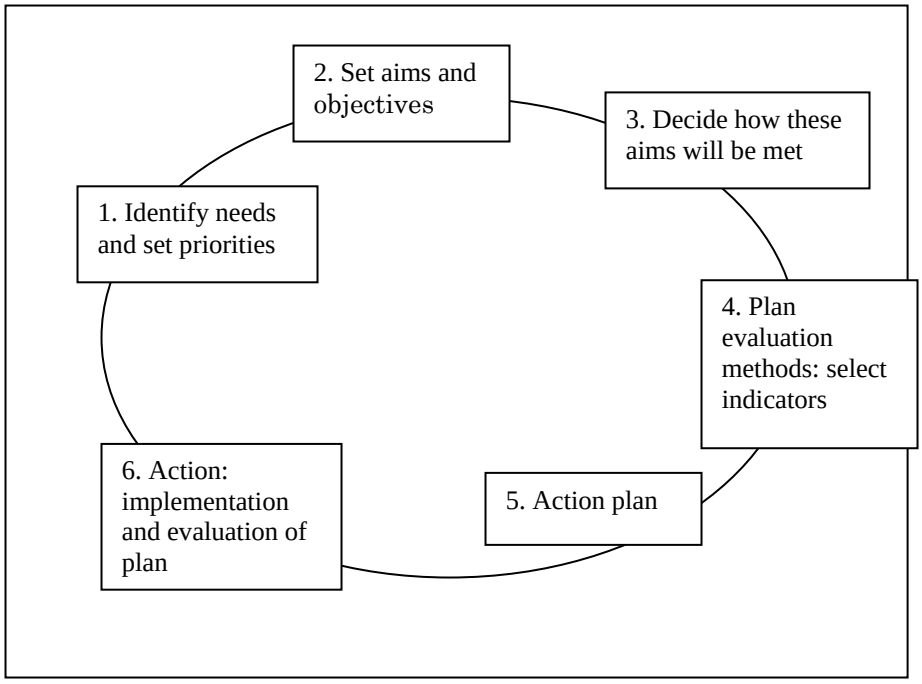
Learning Outcome 4: Physical Development and Movement
The learner will be able to demonstrate an understanding of, and participate in, activities that promote movement and physical development.
The learner in the Foundation Phase enters school with many emerging motor control, body awareness and perceptual motor abilities which need further development. The learners' affective and social responses are usually egocentric. Through discovery, the learner needs to develop the necessary skills for each of the developmental aspects. Using a variety of new functional movements, the learner develops an awareness of the body and how to move in challenging, exploratory and problem-solving ways.



Planning is a process, which ends up with a plan: at its very simplest, a plan should give you answers to three questions:

- What are you trying to achieve?
- What are you going to do?
- How will you know whether you have been successful?

The constituents of effective planning can be summarized as follows:



Reading: Coulson, N., Goldstein, S., Ntuli, A. (1998) *Promoting health in South Africa: An action manual*. Sandton, South Africa: Heinemann, Ch 13.

TASK: This task is broken into four parts.

In pairs, discuss the learning outcomes written for Foundation Phase, in the learning area Life Orientation and the learning outcomes for Arts and Culture. In your discussion, answer the following questions ….

Task One: What do these outcomes actually mean, and are they outcomes which can be achieved or only engaged with? (each pair to take one/two learning outcomes)

Reading: Department of Education (2002), RNCS Grades R - 9 Life Orientation Policy, pp. 9 - 23
Department of Education (2002), RNCS Grades R - 9 Arts and Culture Policy, pp 11 - 35

Then, based on this discussion, decide on a relevant, practical, useful project objective related to these learning outcomes. Remember, a project objective should address the question of how therapeutic knowledge and skills can be integrated within the

curriculum. Write this up on your flipchart paper and provide what you would consider an "indicator of success" for your project.

Task Two: Taking the same outcomes, write up a description of how you as an education therapist could work with the educator to achieve these outcomes.

Then once again, decide on a relevant, practical, useful project objective related to how you are going to "pilot" this, and provide an "indicator of success" for your project.

See the Writing Frame provided by the workshop facilitators and refer to the example below:

Some examples of indicators at school level are given in the table over the page (taken from "the ENHPS indicators for a health promoting school", The European Network of Health Promoting Schools).

Objective	*Indicators*	*Criteria for success*
Key area: dissemination		
To ensure dissemination of the HPS concept within the school	• % of staff actively involved in the implementation of the HPS concept • % of pupils actively involved in the implementation of the HPS concept	• All staff actively involved in the implementation of the HPS concept • All pupils actively involved in the HPS concept • Number and status sufficient to ensure implementation of the HPS concept
Key area: structures		
Members of the whole school community have the opportunity to be involved in decision making	• Structures are in place to ensure the following can participate in decision-making: learners, parents, teaching staff, non-teaching staff, community organisations	• Evidence of active participation
Key area: impact		
School level: curriculum To ensure a range of teaching methods are used which include active learning	• Proportion of teachers using active or experiential learning methods	• Increase in the proportion of teachers using active or experiential learning methods

Task Three: Once again, take the same outcomes you worked with earlier, and write up a description of how, as an education therapist, you can work with the educator to assess the achievement of these outcomes by the learners.

Reading: Department of Education (2002), Life Orientation Policy, pp. 51 - 59

Again, translate this into a project objective, and provide an "indicator of success".

Task Four: Finally, let us consider the following question: "How can the education therapist be involved in the planning of learning programmes". Write this up as a job description using the following format: Description of post (give your "job" a name), Core functions of the post, Key areas of responsibility, Guidelines for working with educators. (see the writing frame in Appendix)

At the end of this activity, each member of the group must write on a single piece of A5 paper, the following incomplete sentence:

"My role as an education therapist in the curriculum is to ..... the achievement of learning outcomes and ..... in order to see if the learner has achieved these outcomes".

This sentence should be completed before the continuation of the workshop. Note: single words or short phrases can be used.

Reading: Access to the Curriculum, pp 46 - 64

Ice-Breaker No 2:

You are divided into 2 groups. In each group, decide on a typical Activity of Daily Living. Decide how you are going to role-play, brain gym/body spell, demonstrate etc etc, the ADL you have chosen. Remember, once again, your group will do present this role-play etc to the other group. The other group has to try and guess the ADL you have chosen.

Section Three: Implementing the action-based programme

The next stage of this training programme is the action-orientated part of the programme. In your project teams (there will be two project teams), you will use one of the two motor activity programmes attached to this training manual, and using the understanding you have gained around the learning outcomes for Life Orientation and the Arts/Culture learning areas, your project team will develop and pilot an integrated learning programme for Foundation Phase in a nearby school (either ordinary or special school).

For understanding, let us go through the tasks ahead:
STEP ONE: Get a project team together (think if there is anyone else you may want in your project team …??? Grade R educator??? Curriculum Advisor???)

STEP TWO: Look at the Foundation Phase learning outcomes for Life Orientation and Arts/Culture
STEP THREE: Use one of the motor activity programmes attached
STEP FOUR: Go into a Foundation Phase classroom, and observe a typical classroom learning activity, look at learning programmes and lesson plans.
STEP FIVE: With the project team, draw up a learning programme or lesson plan, integrating the therapy tools into the learning outcomes
STEP SIX: Review and evaluate how the project has worked.

As you move onto the next section, there are a few important key points that should be highlighted:

Key Points

- ✓ In drawing up a project plan, we have used the word objectives to refer to what we need to achieve. In drawing up a learning programme, educators use the word outcome to refer to what the learner needs to achieve.
- ✓ In identifying indicators, we have specified the target that will help us assess whether or not we have achieved the objective. In specifying assessment standards in the RNCS, the Department of Education has provided the educator with a standard for determining whether or not the learner has achieved the learning outcome.
- ✓ Engaging with the outcome is the same as "the process of implementing the project"
- ✓ Whether or not the learner achieved the outcome, is the same as evaluating the product of the project - "Do you have a practical way in which you can work with teachers to integrate therapeutic skills into the curriculum?"

Key Points

- ✓ ……
- ✓ ……
- ✓ ……
- ✓ ……

See the last section of this unit for the formal evaluation

Reading: Coulson, N., Goldstein, S., Ntuli, A. (1998) *Promoting health in South Africa: An action manual.* Sandton, South Africa: Heinemann, Ch 13.

Evaluation is an important part of any programme or project you develop. You need to evaluate all aspects of the programme including things like: whether or not your programme met the needs of the group, whether your programme provided the right content at the right level, whether your programme was useful in the everyday lives of the people. With all these things to consider, evaluation must often be multi-tiered, and should be done at different times during the process, and once you have finished.

A Theory of Change Approach to Evaluation

See chart (HP seminar: Dixey)

Section Five: Touching on the educator-therapist relationship

Key Points
- ✓ Collaborator
- ✓ Consultant
- ✓ Empowerer

Engelbrecht describes the education support professionals including therapists as having 2 roles:
- Role as a collaborator
- Role as a consultant

Reading: Engelbrecht P. (2001). *Promoting Learning Development: Preventing and working with barriers to learning.* Pretoria: Van

Role as a collaborator:
With a change in role to collaboration you are more likely to enjoy your work and get results. There will be mutual participation and joint responsibility as well as a caring attitude amongst the participants. You will be able to pool your resources and talents with others, to the advantage of all.

You can be a part of a collaborative team helping create a sense of belonging by facilitating the relationships between the group members, including emotional and technical support for one another.

Role as a consultant:
You have unique knowledge and skills as a result of your training which you can share with others.

Consultation:
Is an indirect process, there is no direct contact with the learners
It is based on mutual respect – respect of the consultant's expertise and the consultee's views
The consultant has different responsibilities from the consultee who is responsible for implementation.

Effective consultation needs enthusiasm, communication skills and mutulally desired outcomes.

Training and Project Evaluation

First training session

Layout of training manual:		
Readings:		

Training technique		
Did the training measure up to expectations?		

Project diary

What was important for me from the initial training programme?
What was important for me from the project as a whole? (initial training, project implementation and the evaluation stages)
What were the key concepts which were the most useful?
How will I use the training and the active learning from the project for new projects?

References:

Department of Education (2001, July). Education White Paper 6: Special needs education: Building an inclusive education and training system. Pretoria: Education Department.

Reading: Coulson, N., Goldstein, S., Ntuli, A. (1998) Promoting health in South Africa: An action manual. Sandton, South Africa: Heinemann.

Writing Frames:

Section Two, Task Two

Project Objective	Activities/Actions	Indicators/Criteria for success
Learning Outcome:		
Learning Outcome:		

Section Two, Task Four:

DESCRIPTION OF POST: _____

(As an OT, PT or STA, your official job description is education therapist…. What do you think it could be?)

CORE FUNCTIONS OF THE POST:

1.
2.
3.

KEY AREAS OF RESPONSIBILITY (PS: here this refers particularly to your involvement in the curriculum)

GUIDELINES FOR WORKING WITH EDUCATORS (PS: here, we want you to think about what would help you as an education therapist to succeed in working with educators)

READINGS

Annexure A: Motoriese Aktiwiteite

Annexure B: Motoriese Ontwikkeling en Ondersteuning

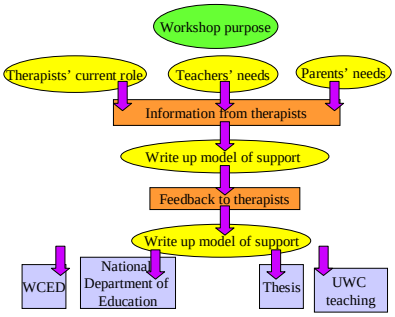
Appendix Vll: Presentation to therapists

Slide 1

The role of therapists in the education support services

Trish Struthers
November 2004

Slide 2



Slide 3

Where does my research fit in?

- I am not determining policy: White Paper 6 is the guiding policy document
- My research will feed into the process of implementing the policy and the guidelines for implementation
- I want to hear what you have to say and pass this information on to national and provincial education departments

Slide 4

Participatory research

- I see this part of my research as a partnership with all of you
- I will respect your views and do my best to present them accurately (but anonymously)
- However, in my final thesis I will be drawing on the interviews with the teachers, the parents and international literature to discuss in depth the results of my research

Slide 5

Outline of presentation

- Results of questionnaires: What are therapists currently doing
- Results of focus group discussions: What support is needed?
  - Teachers
  - Parents

Slide 6

Direct learner support

- Hearing/speech/communication skills
- Activities of daily living/self maintenance tasks
- Life skills/ social skills/Home management
- Work and productive activities: Educational activities
- Motor function activities
- Play or leisure activities
- Counselling

Slide 7

Focus group discussions with teachers and parents

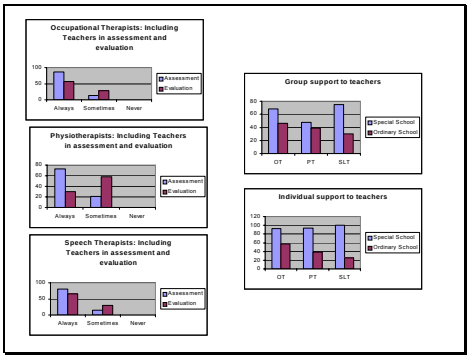
- 2 EMDCs
- Teachers from special schools
- Teachers from ordinary schools
- Parents of learners at special schools
- Parents of children not in school

Slide 8

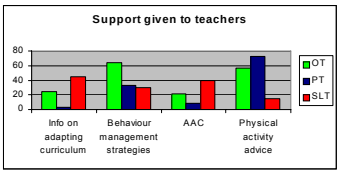
Teachers need for support

- Policy of inclusive education
- Adapting the curriculum
- Want direct support
- Involvement in assessment
- Support for parents
- Advocacy in the community
- Teacher - therapist relationship

Slide 9



Slide 10



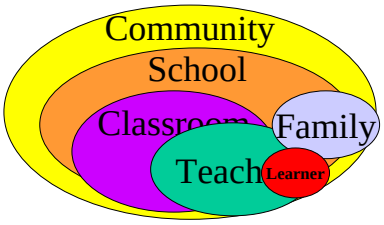
Slide 11

Parents need for support

- Access to school and therapy
- Parents skills
- Child's communication difficulties
- Community involvement
- Advocacy needed
- Parent's emotional difficulties
- Parent - therapist relationship

Slide 12

Barriers to learning



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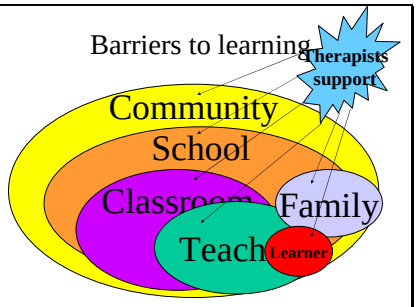


Slide 14

Factors affecting teaching & learning: Barriers to learning and development

- Physical, mental, sensory, neurological and developmental impairments
- Psycho-social disturbances
- Differences in intellectual ability
- Particular life experiences
- Socio-economic deprivation
- Negative attitudes to and stereotyping of differences

Slide 15

- An inflexible curriculum
- Inappropriate languages of language of learning and teaching
- Inappropriate communication
- Inaccessible and unsafe built environments
- Inadequate policies and legislation
- The non-recognition and non-involvement of parents
- Inadequately and inappropriately trained education managers

(Department of Education, 2001)

Slide 16

Direct support

- is support given directly to the learner
- has an impact on a particular learner or group of learners

Indirect support

- is support given to the teacher, the school, the family and the community
- has an impact on all learners

Slide 17

District based support team

- The main aim of the district based support team is to provide indirect support to learners through supporting educators and school management, with a particular focus on curriculum and institutional development
- A secondary aim is to provide direct support to learners where site based support teams are unable to respond to particular learning needs

Slide 18

Prevention of barriers to learning

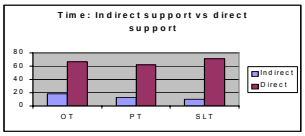
- In addition to addressing barriers to learning
- Need for preventative programmes - build effective teaching and learning environment
- Need for programmes on social inclusion
- Need to identify learners "at risk"
- Need to identify educators "at risk"

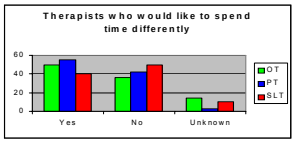
Slide 19

What indirect support do you need to give teachers, parents, the school, the community to address the barriers to learning?

How much of your time would you like to be spending on indirect support?

Slide 20





Slide 21

Question 1

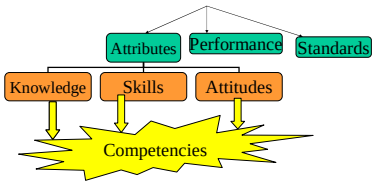
What support do teachers and parents need from therapists to address the barriers to learning?

Slide 22

- "What knowledge and skills do we as therapists have, or need to have, to provide appropriate support for all learners in an inclusive education system, and not only for the small number of learners who are currently in special schools?"

Slide 23

"A **competent** professional has the attributes necessary for job performance to the appropriate standards"



Slide 24

Question 2

What competencies are needed to be able to provide this support?

What knowledge, skills and attitudes are needed?

Don't say WHO will provide the support (i.e. What qualification the person needs)

Appendix Vlll: Outline of meetings and workshops with therapists

Date	Participants	Purpose
9 March 2001	Therapists at one special school	Focus group to present proposal and jointly plan the way forward.
14 March 2001	Representatives of school therapists	Meeting to get permission to make presentation to all therapists at workshop.
3 April 2001	All Western Cape Province school therapists	Workshop to present information from proposal on inclusive education and health promoting schools. Therapists to complete Questionnaire A (Appendix x). This was used to design long questionnaire.
June 2001	Individual therapists	Consultation about content of Questionnaires B and C.
September 2001	Therapists at one special school	Meeting involving pilot testing of questionnaire and discussion of changes needed.
October/November 2001	All school therapists in Western Cape Province	Distribution and collection of Questionnaires B and C. Personal contact or telephonic contact to ensure commitment to the research and improve rate of return from school therapists.
19/20 September 2002	All school therapists	Information sharing workshop: To present information on inclusive education and the changing role of therapists in South Africa and New Zealand.
August 2003 & subsequently many meetings in following months	WCED therapist at head office	To discuss working collaboratively. Planning and implementing activities related to research and training of therapists.
9 August 2003	Therapists at special school Urban EMDC	Invite parents to FGD.
9 September 2003	All therapists Urban EMDC	Meeting to explain research to date and future plans to work with therapists.
16 September	All therapists Rural EMDC	Meeting to explain research to date and future plans to work with therapists.
13 October 2003	All therapists Rural EMDC	Workshop 1a: To identify support teachers, schools, community need from therapists.
13 November 2003	All therapists Urban EMDC	Workshop 1b: To identify support teachers, schools, community need from therapists.
20 October 2004	All therapists Urban EMDC	Workshop 2a: To present data from parents and teachers and identify competencies required by therapists to give support.
11 November 2004	All therapists Rural EMDC	Workshop 2b: To present data from parents and teachers and identify competencies required by therapists to give support.
November 2004	All therapists Urban & Rural EMDC	Collated data from above two workshops sent to therapists for verification.

Appendix lX: Letter to principals

University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY
14 August 2003

Mr M
Principal
A Primary School
Cape Metropole

Dear Mr M

Research interviews with educators

This letter is to follow-up on the discussion that we had on the telephone earlier today. I would like to thank you for your permission to conduct some of my research at A Primary School.

I am currently registered for a doctorate and am trying to develop a model of support for learners by occupational therapists; physiotherapists and speech and language therapists bearing in mind the policy changes that have taken place over the past few years.

As a part of this research I need to find out what support teachers require to give effective support to learners who area experiencing difficulties and barriers to learning. I would like to do a group interview with about 6-8 teachers.

I have obtained permission to do the study from the Western Cape Education Department. The study will be conducted in 2 EMDC's – one in the urban area: The Urban EMDC, and one in a more rural area: the Rural EMDC. I discussed the choice of schools with Ms x at the EMDC and she recommended your school.

The type of question that I will be asking the teachers will be about the difficulties learners may be experiencing; and if they have had support from therapists in the past; and what support they would like to get from the therapists. The people who participate in the interview would remain anonymous and do so on a voluntary basis. The information that I get will be extremely useful to developing effective training for therapists who need to give appropriate support to learners.

I am particularly interested in doing an interview in a school that has identified itself as a health promoting school to learn how therapists can help build this whole school approach.

The interview would take place at a time that is suitable for the school, during the third term. I would need 1 to 1 ½ hours and would provide refreshments to make the occasion a little more relaxed. I would like to tape-record the interview in order to ensure that I hear everything and would take notes. It is likely that there will be a co-facilitator in order to make it easier to take notes and ask questions. I hope about 8 teachers would be able to participate in the interview.

I would love to give feedback to the teachers as the research progresses.

Mr Wessels, from the WCED, granted me permission to do the study if the principal of the school is in agreement. I will attach a copy of his letter.

I look forward to the opportunity to work with you.

Yours sincerely

Trish Struthers
(Senior lecturer)

Appendix X: Letter to therapists

University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY

25th June 2004

Dear Colleagues
Research on role of therapists

I feel I owe you an apology for concern related to my part in the workshop that took place at X School.

As some of you know I worked at Eros School for 6 years and do understand the pressures therapists are under and know that time out of work for in-service training is valuable.

We did come well prepared, but unfortunately things did not go according to plan.

I know the rules of research and getting permission is top of the list. I am sorry that somehow in the confusion at the beginning this didn't happen in a clear way. But please read on for a minute and let me explain. The reason I am doing the research is because of how the changes resulting from a new education policy are already affecting therapists and will do so even more in the future.

Changes have happened in the way therapists work internationally. My research aims at involving the therapists in two education districts so that your voices can be heard in this process. The result of my research is intended to develop "An integrated model of educational support: The role of occupational therapy, physiotherapy and speech therapy".

I still hope to be able to hear what you have to say. My current proposal to you is to hold a workshop in the third term when I can firstly present to you:

1) The information about therapists' current role that I gathered from the questionnaire I sent out.

2) Information from focus groups discussions I have had with teachers and parents.

Then to spend the next part of the workshop finding out from you:

1) What support do you need to provide teachers and parents to be able to address the "barriers to learning"? This would include looking at where the most appropriate place is for therapists to be placed and how therapists could work with teachers and parents.

2) What competencies (skills and knowledge) do therapists need to provide this support.

My plan is then to take this information, analyse it and develop the model. I will then come back in fourth term 2004 to present what I have developed, get your comments and make appropriate changes.

I haven't always found the research process easy. It certainly is slower than I'd hoped, but I do believe it is one way for as many therapists as possible to have a say in the implementation of the new education system. I would hope we can still work as partners in the future.

Yours sincerely

Trish Struthers

Appendix XI: Permission from WCED

Enquiries Frances Wessels
Imibuzo
Telefoon
Telephone 467-2593
IFoni
Faks
Fax 467-2562
IFeksi
Verwysing
Reference
ISalathiso

Wes-Kaap Onderwysdepartement
Western Cape Education Department
ISebe leMfundo leNtshona Koloni

Ms P Struthers
Private Bag X17
BELLVILLE
7535

RESEARCH PROPOSAL: Development of an integrated model of educational support: The role of occupational therapy, physiotherapy and speech therapy within a health promoting schools framework

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, teachers and learners are under no obligation to assist you in your investigation.
2. Principals, teachers, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. All research should be conducted after school as educators' programmes should not be interrupted.
5. Should you wish to extend the period of your survey at the schools, please contact F Wessels at the contact numbers above.
6. The investigation is not conducted during the fourth school term.
7. A photocopy of this letter is submitted to the principal of each school where the intended research is to be conducted.
8. A brief summary of the content, findings and recommendations is provided to the Director: Research.
9. The Department receives a copy of the completed report/dissertation/thesis addressed to:

   The Director: Research
   Western Cape Education Department
   Private Bag 9114
   CAPE TOWN
   8000

We wish you success in your research.

Kind regards.

Fwessels

pp **HEAD: EDUCATION**
DATE: 23/07/2001

MELD ASSEBLIEF VERWYSINGSNOMMERS IN ALLE KORRESPONDENSIE / PLEASE QUOTE REFERENCE NUMBERS IN ALL CORRESPONDENCE / NCEDA UBHALE INOMBOLO ZESALATHISO KUYO YONKE IMBALELWANO

Appendix Xll: Letter to teachers

University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY
11 March 2003

Dear Participants,

Thank you for being here today.

I am from the University of the Western Cape and am doing some research.

I am trying to learn more about the support that therapists – occupational therapists, physiotherapists and speech therapists – need to give in schools so learners can participate as fully as possible in education.

Your participation in this group discussion is completely voluntary; it is your choice to participate. If you are not happy to participate you may withdraw at any time.

You will remain anonymous. I will not use any names in the recording. No one will know who has said anything in particular. This is to enable all of you to be as open and honest about your feelings and experiences as possible.

I will be recording the group discussion using a tape recorder to make it easier for me to remember everything that has been said. I will also be making notes on the newsprint to make it possible for all of you to see the main points of the discussion, and to make any corrections that are needed to what I have written.

I have brought a Xhosa speaking student with me to assist me for anyone who would like to contribute to the discussion in Xhosa. I will record summary of the English translation on the newsprint.

Many thanks for your time

Yours sincerely

Trish Struthers

Appendix Xlll: Informed consent from therapists

University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY

11TH NOVEMBER 2004

THERAPIST WORKSHOP

I agree to participate in the workshop that is being run by Trish Struthers.

I understand that my input will be used in her research and the information will be given to the Western Cape Department of Education and to the National Education Department.

I understand that I will remain anonymous and may withdraw at any time.

Please tick your discipline:
Occupational therapist

Physiotherapist

Speech and language therapist

Name:……

School: ……..

Signature: …….

Appendix XlV: Supplementary results of survey of therapists

Table 5.5: Mean number of children treated by each therapist per year (N=350)

Setting for treating pre-school children	OT n (range)		PT n (range)		SLT n (range)	
Special preschool	33.0	(2-400)	42.0	(1-720)	14.0	(1-35)
Ordinary preschool	12.8	(1-35)	130.0	(4-720)	21.4	(4-60)
Day care centre	156.8	(2-600)	47.5	(2-300)	5.0	(3-7)
Learner's home	3.0	(2-4)	3.4	(1-10)	1.7	(1-2)
Community health centre	31.0	(10-100)	24.7	(1-100)	200.0	(0-200)
State hospital	19.4	(1-80)	21.0	(2-100)	88.0	(2-200)
Private practice/private hospital	18.4	(2-80)	30.5	(1-720)	16.8	(2-70)
Clinic run by NGO	0	(0)	11.3	(5-20)	6.0	(0-6)
Setting for treating school-aged children						
Special school	51.5	(2-204)	42.7	(3-150)	62.4	(1-160)
Ordinary school	28.0	(1-200)	78.3	(25-180)	14.8	(1-65)
Day care centre	151.0	(2-300)	104.6	(4-300)	0	(0)
Learner's home	0	(0)	4.2	(1-10)	1.5	(1-3)
Community health centre	25.0	(10-80)	12.8	(2-25)	200.0	(0-200)
State hospital	15.2	(2-80)	16.1	(1-100)	57.5	(2-200)
Private practice/private hospital	20.8	(1-150)	21.7	(1-359)	19.3	(1-128)
Other	17.5	(15-20)	36.6	(1-100)	5.0	(0-5)

Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Table 5.6: Percentage of therapists providing individual or group treatment (n=82)

Individual or group treatment	Frequency of treatment	OT	PT	SLT
Individual learners	Often worked with individuals	68	91	76
	Occasionally worked with individuals	29	6	24
Groups of learners	Often worked with groups	82	58	90
	Occasionally worked with groups	18	39	3

Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Table 5.7: Percentage of therapists who evaluate their direct support/treatment (N=82)

Evaluation process	OT	PT	SLT
Always evaluated interventions	68	52	81
Sometimes evaluated interventions	29	45	19
Used "regular" assessment procedures	61	55	81
Evaluated if "goal was achieved within proposed timeframe"	57	58	80

Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Table 5.8: Percentage of therapists who make decisions jointly with others (N=82)

Person making decision therapist	Frequency	Identification of support needs and treatment goals			Evaluation of outcome of support		
		OT	PT	SLT	OT	PT	SLT
Learner	Always	43	70	67	46	79	81
	Sometimes	32	24	29	29	18	14
Parents	Always	29	52	52	21	24	38
	Sometimes	64	33	43	54	55	43
Teacher	Always	86	73	81	61	30	67
	Sometimes	14	21	14	25	58	29
Occupational therapist	Always	36	70	38	18	36	24
	Sometimes	7	27	57	21	45	48
Physiotherapist	Always	36	48	33	21	21	14
	Sometimes	29	0	48	39	18	42
Speech and language therapist	Always	21	36	43	18	6	24
	Sometimes	39	33	10	39	45	0
Psychologist	Always	39	39	43	25	12	10
	Sometimes	46	39	57	43	39	57
School nurse	Always	29	27	19	14	9	0
	Sometimes	46	45	48	43	42	29
Social worker	Always	7	3	10	4	3	0
	Sometimes	32	21	14	25	12	14

Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Table 5.9: Therapists training non-teaching school personnel (N=82)

School personnel	OT %	PT %	SLT %
Classroom assistants	57	79	66
Bus drivers	43	73	10
Hostel personnel	25	42	29
Administrative personnel	11	27	10

Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Table 5.10: Therapists' role in the manufacture of assistive devices (N=82)

Assistive device	OT %	PT %	SLT %
Ear moulds	0	0	14
Arm / hand splints	50	15	0
Leg / foot splints	14	12	0
Special seating	36	61	0
Special standing support	21	48	0

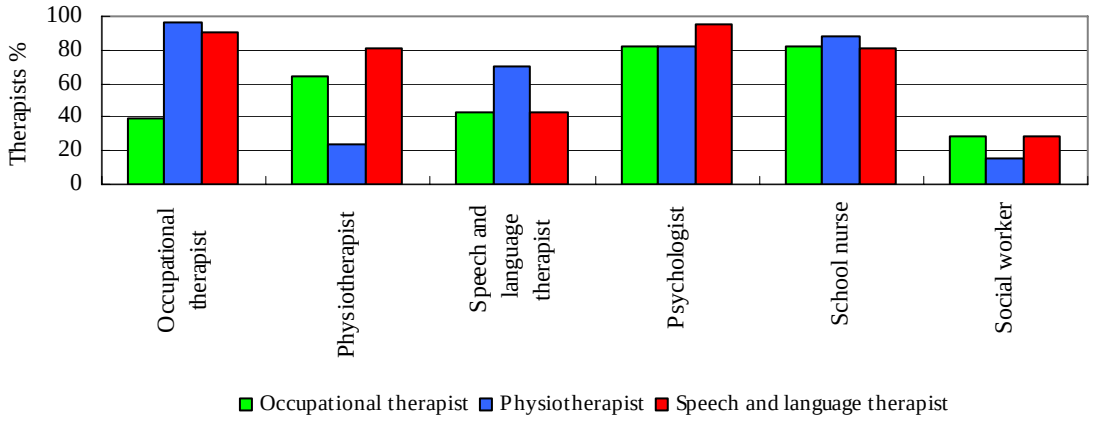
Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Table 5.11: Therapists' role in maintenance and repair of assistive devices (N=82)

	OT %	PT %	SLT %
Maintain assistive devices	32	52	38
Repair assistive devices	32	33	19
Teach learners maintenance and repair	7	30	33
Involve parents in maintenance and repair	7	27	38
Arrange for repairs to be done by other	25	90	48
No role in maintenance and repair	25	3	10

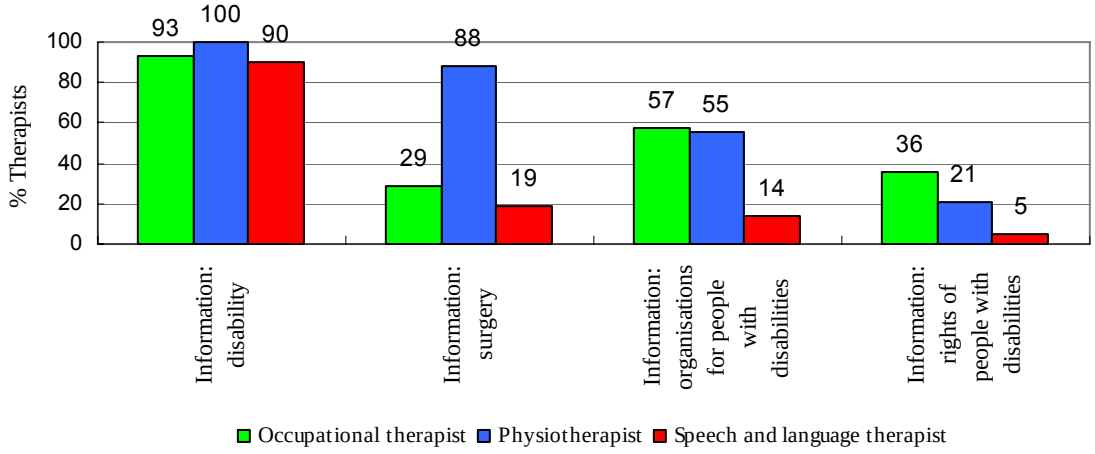
Abbreviations: OT=occupational therapist, PT=physiotherapist, SLT=speech and language therapist

Figure 5.11: Professional personnel at therapists' workplace (N=82)



Support for teachers

Figure 5.13: Information for teachers (N=82)



Support for parents:

Figure 5.15: Support in the home (N=82)

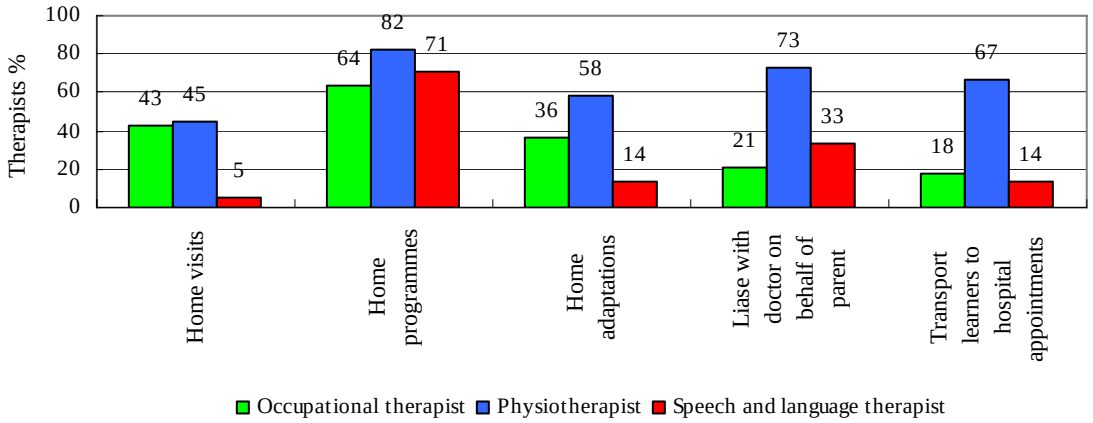


Figure 5.16: Information for parents (N=82)

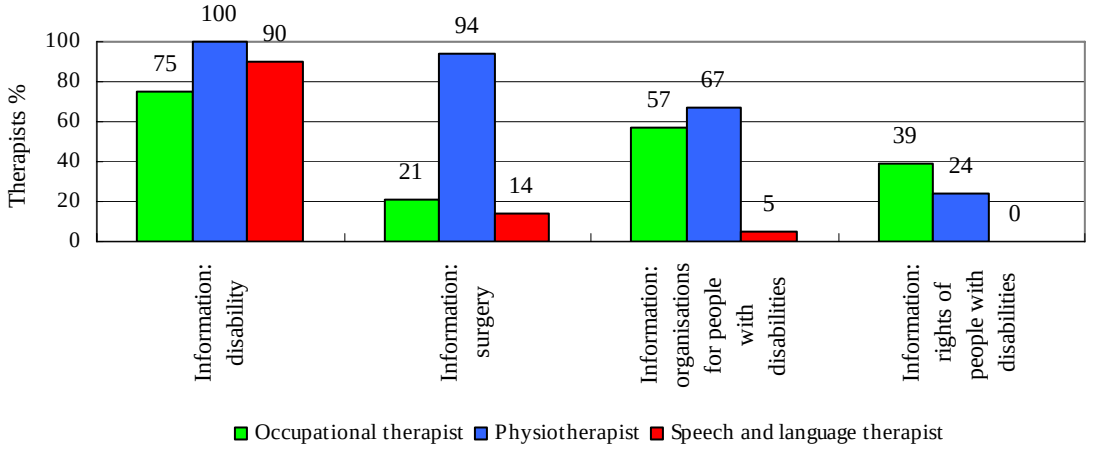
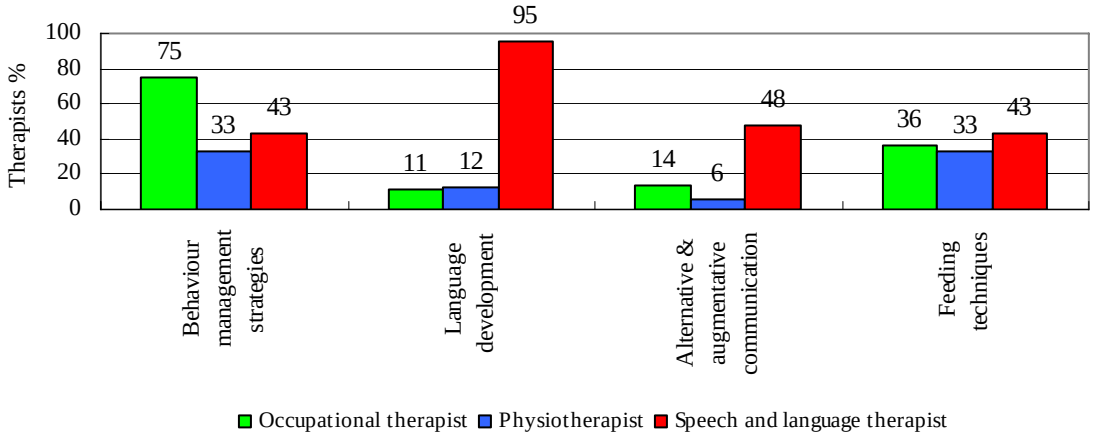


Figure 5.17: Development of parents' skills (N=82)



Provision of assistive devices

Figure 5.19: Teachers and assistive devices (N=82)

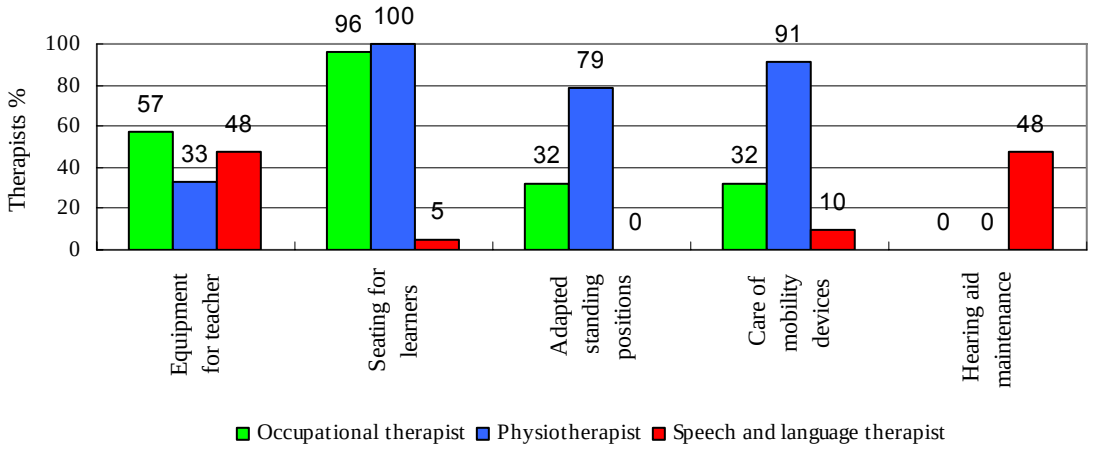
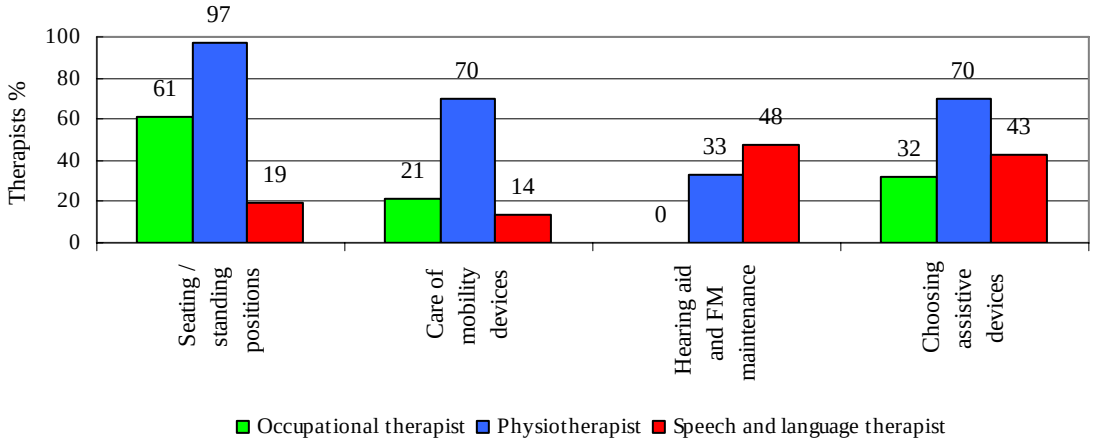
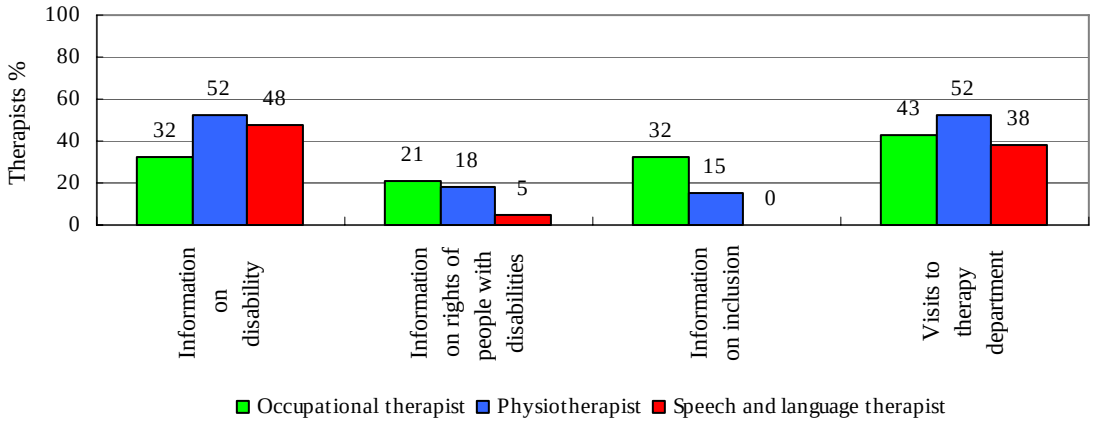


Figure 5.20: Parents & assistive devices (N=82)



Support for learners in ordinary schools

Figure 5.21: Learners in ordinary schools (N=82)



Support for the school environment

Figure 5.22: Adaptations to school environment (N=82)

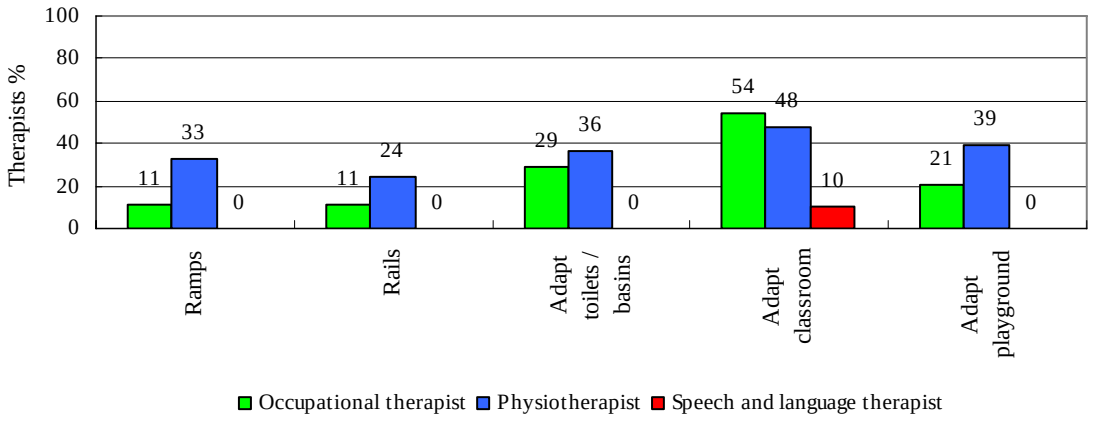
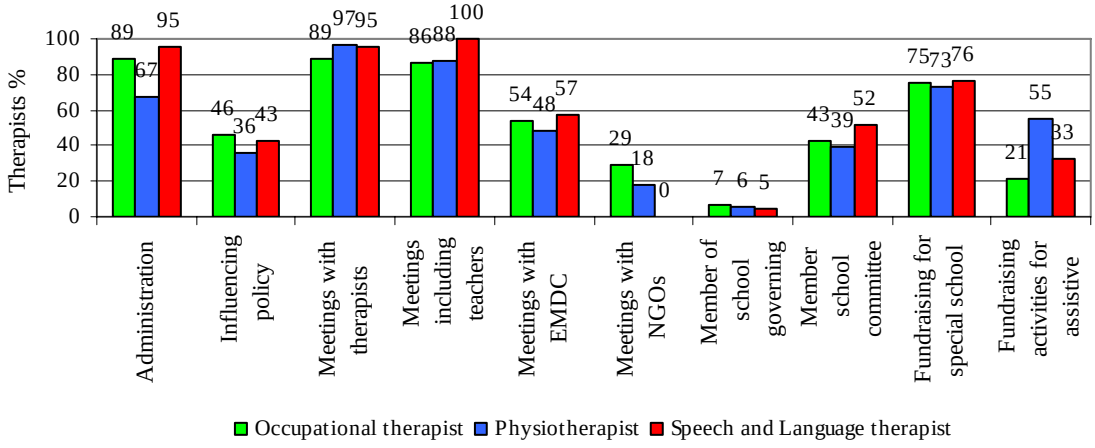


Figure 5.23: Management responsibilities (N=82)



Support for the community

Figure 5.24: Information provided to the community (N=82)

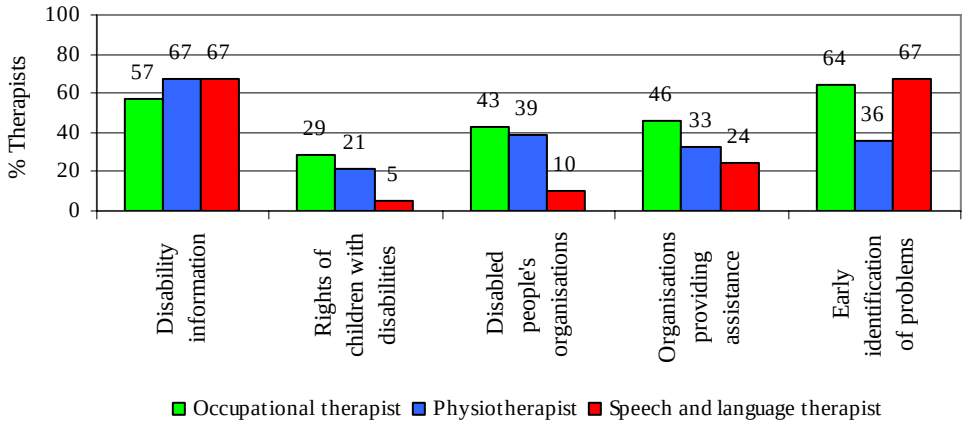
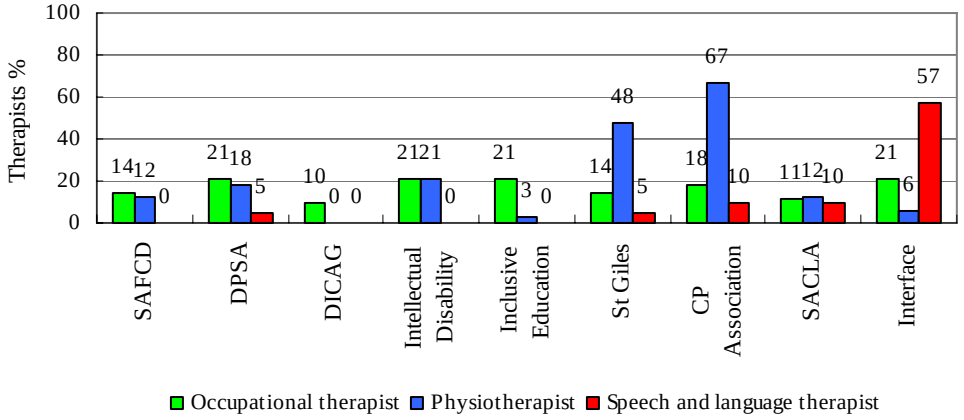


Figure 5.25: Contact with community organisations (N=82)



Abbreviations: SAFCD=South African Federal Council on Disability, DPSA=Disabled People of South Africa, DICAG=Disabled Children's Action Group, Intellectual Disability=Western Cape Forum for Intellectual Disability, Inclusive Education=Western Cape Forum for Inclusive Education, St Giles=St Giles Sports for the Disabled, CP Association=Cerebral Palsy Association, SACLA=South African Christian Leadership Association

Capacity development of therapists

Figure 5.27: Further training of therapists (N=82)

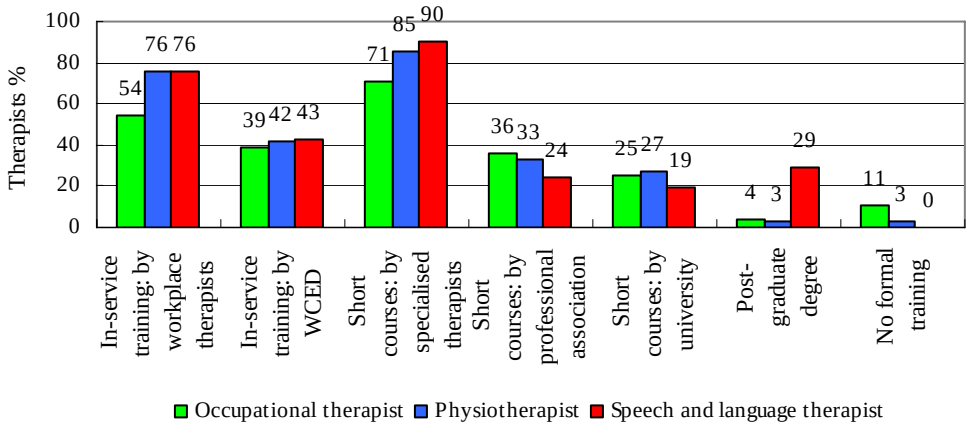
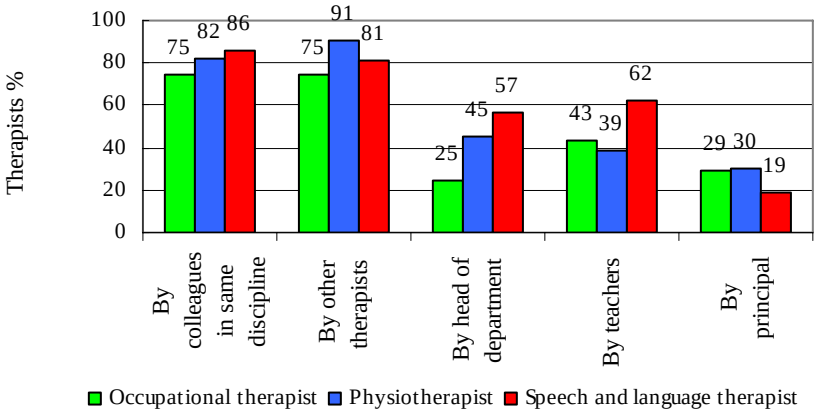
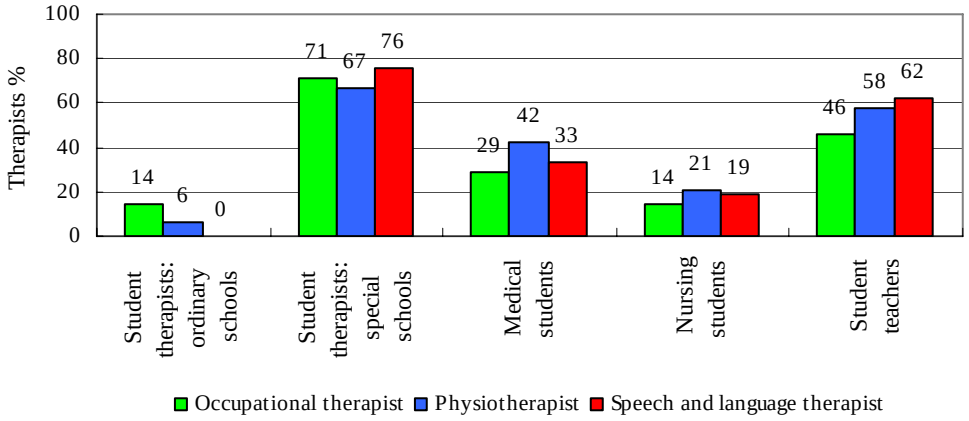


Figure 5.28: Mentoring of therapists (N=82)



Capacity development of others by the therapists

Figure 5.29: Therapists training others (N=82)



Appendix XV: Roles of therapists

Roles of therapists as indicated by at least 10%* of the sample

Occupational therapy – Physiotherapy - Speech & language therapy

Hearing/speech/communication skills
- oral-motor therapy

Activities of daily living
- toilet hygiene
- personal device care
- dressing
- feeding
- medicine routine

Life skills/social skills
- socialisation
- community mobility

Motor function activities
- fine motor functional activities
- gross motor functional activities
- posture correction
- seating positioning
- alternative positioning in school

Play & leisure activities
- play exploration
- play performance
- sport for disabled learners
- extra-mural activities

Support for teacher
- **curriculum support:**
  - evaluation & assessment
  - programme development
  - behaviour management strategies
- information on:
  - disability
  - learner's surgery
  - organisations for people with disabilities
- skills taught: feeding techniques

Provision of assistive devices
(provision, maintenance, repair)
- aids for feeding
- special seating
- aids for writing
- aids for teacher
- advise parents in choosing assistive devices

Support for parent
- home programmes
- home adaptations
- liaise with doctor
- transport learners to hospital appointments
- information on:
  - disability
  - surgery
- skills taught:
  - behaviour management strategies
  - language development
  - feeding techniques

Support for environment
- adaptations to school classroom

Support for learners in ordinary schools
- information on disability

Support for community
- early identification of problems
- training volunteers

Information on:
- disability
- disabled people's organisations
- organisations that provide assistance for children with disabilities

Advocacy
- with teachers in ordinary schools for inclusion

Occupational therapy

Hearing/speech/ communication skills
- visual perception skills

Activities of daily living
- grooming
- bathing & showering

Life skills/social skills
- sexual expression

Home management
- clothing care
- cleaning the home
- meal preparation & cleanup
- shopping
- money management

Work & productive activities
- vocational exploration
- work performance preparation / vocational training
- work acquisition / placement

Physiotherapy

Play & leisure activities
- Hydrotherapy

Provision of assistive devices
(provision, maintenance, repair)
- Manual & electric wheelchairs

Speech & language therapy

Hearing/speech/ communication skills
- Hearing tests

Provision of assistive devices
(provision, maintenance, repair)
- Hearing aids

Occupational therapy – Physiotherapy

Life skills/social skills
- health maintenance
- emergency response to hazardous situations
- sexual expression

Motor function activities
- motor co-ordination activities

Play & leisure activities
- prevention & treatment of sports injuries
- horse riding
- dance therapy

Counselling
- learners
- **parents**

Support for teacher
- **curriculum support: physical activity**
- information on rights of people with disabilities
- skills taught: lifting techniques

Support for parent
- home visits
- information on:
  - organisations for people with disabilities
  - rights of people with disabilities
- skills taught: lifting techniques

Assistive devices
(provision, maintenance, repair)
- walking aids
- standing aids
- dressing aids

Support for learners in ordinary schools
- information on:
  - rights of people with disabilities
  - inclusion

Support for environment
- adaptations: ramps; rails; toilets & basins
- formal counselling for parents
- adaptations to school playground

Support for community
- information on: rights of children with disabilities

Occupational therapy – Speech & language therapy

Hearing/speech/communication skills
- auditory perceptual skills
- language and speech skills
- sign language
- functional communication
- reading and spelling remediation

Activities of daily living
- oral hygiene
- bathing/showering
- medication routine

Counselling learners

Support for teacher
- **curriculum support:**
  - adaptation: content, presentation
  - language development
  - advice on AAC*

Support for parent
- skills taught: AAC*

Assistive devices
(provision, maintenance, repair)
- communication aids

*AAC: Alternative and augmentative communication systems

Physiotherapy – Speech & language therapy
- No overlap

Roles of therapists as indicated by at least 20%* of the sample

Occupational therapy – Physiotherapy – Speech & language therapy

Activities of daily living
- personal device care
- dressing
- feeding and eating

Life skills/social skills
- socialisation

Motor function activities
- posture correction

Play & leisure activities
- play exploration & performance
- sport for disabled learners

Support for teacher
- curriculum support:
  - evaluation & assessment
  - programme development
  - behaviour management strategies
- information on disability

skills taught: feeding techniques

Support for learners in ordinary schools
- information on disability

Assistive devices
(provision, maintenance, repair)
- feeding aids
- aids for teacher
- advise parents in choosing assistive devices

Support for parent
- home programmes
- liaise with doctor on behalf of parent
- information on disability
- skills taught:
  - behaviour management strategies
  - feeding techniques

Support for community
- early identification of problems
- training volunteers
- information on:
  - disability
  - organisations that provide assistance for children with disabilities

Occupational therapy – Physiotherapy

Activities of daily living
- toilet hygiene
- dressing

Life skills/social skills
- health maintenance
- community mobility

Motor function activities
- fine motor functional activities
- gross motor function activities
- motor co-ordination activities
- seating positioning
- alternative positioning

Play & leisure activities
- extra-mural activities

Assistive devices
(provision, maintenance, repair)
- special seating
- special standing support
- aids for dressing

Support for environment
- adaptations: toilets & basins
- adaptations in school classroom; school playground

Support for teacher
- advice on adapting & promoting physical activity to include all learners
- information on:
  - surgery
  - organisations for people with disabilities
  - rights of people with disabilities
- skills taught: lifting techniques

Support for parent
- home visits
- home adaptations
- information on:
  - surgery
  - organisations for people with disabilities
  - rights of people with disabilities
- advice on lifting techniques and back care

Support for community
- information on:
  - rights of children with disabilities
  - disabled people's organisations

Advocacy
- with teachers in ordinary schools for inclusion

Occupational therapy – Speech & language therapy

Hearing/speech/communication skills
- oral-motor therapy
- AAC*
- functional communication
- reading and spelling remediation

Activities of daily living
- oral hygiene

Support for teacher
- curriculum support:
- adaptation, presentation
- advice on language development
- AAC*

Assistive devices
(provision, maintenance, repair)
writing aids

Physiotherapy – Speech & language therapy

Activities of daily living
- Personal device care

Occupational therapy

Hearing/speech/ communication skills
- visual perception skills

Activities of daily living
- grooming
- bathing/showering

Life skills/social skills
- emergency response to hazardous situations
- sexual expression

Home management
- clothing care
- cleaning the home
- meal preparation and cleanup
- shopping
- money management

Work & productive activities
- vocational exploration
- work performance preparation / vocational training
- work acquisition / placement

Counselling
- learners
- **parents**

Physiotherapy

Play & leisure activities
- prevention & treatment of sports injuries
- hydrotherapy
- horse riding
- dance therapy

Support for parent
- transport learners to hospital appointments

Assistive devices (provision, maintenance, repair)
- walking aids
- manual & electric wheelchairs

Support for environment
- adaptations: ramps; rails

Speech & language therapy

Hearing/speech/ communication skills
- hearing tests
- auditory perceptual skills
- language and speech skills

Support for teacher
- curriculum support**:**
  - content
  - language development
  - AAC*

Support for parent
- skills taught:
  - language development
  - AAC*

Assistive devices (provision, maintenance, repair)
- hearing aids
- communication aids

Roles of therapists (as indicated by at least 40%* of the sample)

Occupational therapy – Physiotherapy - Speech & Language Therapy

Support for teacher
- information on: disability

Support for parent
- information on: disability

Support for community
- information on disability

Occupational Therapy – Physiotherapy

Activities of daily living
- **dressing**

Motor function activities
- **fine motor functional activities**
- **gross motor functional activities**
- **motor co-ordination activities**
- **seating positioning**
- **alternative positioning**

Play & leisure activities
- **play exploration**
- **sport for disabled learners**

Support for teacher
- **curriculum support**
  - **advice on adapting & promoting physical activity to include all learners**
- information on disabled people's organisations

Support for parents
- **home visits**
- **information on disabled people's organisations**

Assistive devices
- **special seating**
- **provide advice on home adaptations**
- **advice on seating and standing positions at home**
- **adaptations in school classroom**
- **advice on seating for learners**
- **alternative positioning in school**

Support for community
- information on disabled people's organisations

Physiotherapy – Speech & Language Therapy

Assistive devices
(provision, maintenance, repair)
- **involve parents in choosing assistive devices**

Support for learners in ordinary schools
- information on disability

Occupational Therapy – Speech & Language Therapy

Life skills/social skills
- **Socialisation**

Support for parent
- Skills taught: behaviour management strategies

Assistive devices
(provision, maintenance, repair)
- **Writing aids**
- **Feeding aids**

Support for community
- Early identification of problems

Occupational therapy

Hearing/speech/ communication skills
- **visual perception skills**

Activities of daily living
- **toilet hygiene**

Home management
- **money management**

Work & productive activities
- **vocational exploration**
- **work performance preparation / vocational training**
- **work acquisition / placement**

Play & leisure activities
- **play performance**

Assistive devices
(provision, maintenance, repair)
- **dressing aids**
- **arm/hand splints**

Support for teacher
- curriculum support:
  - **behaviour management strategies**

Physiotherapy

Activities of daily living
- **personal device care**

Play & leisure activities
- **prevention & treatment of sports injuries**
- **hydrotherapy**

Support for teacher
- information on: surgery
- skills taught: lifting techniques

Support for parent
- information on: surgery
- lifting techniques and back care
- **liaise with doctor on behalf of parent**
- **transport learners to hospital appointments**

Assistive devices
(provision, maintenance, repair)
- **walking aids**
- **manual & electric wheelchairs**
- **standing aids**

Speech & Language therapy

Hearing/speech/ communication skills
- **hearing tests**
- **auditory perceptual skills**
- **language and speech skills**
- **oral-motor therapy**
- **AAC***
- **functional communication**
- **reading and spelling remediation**

Support for teacher
- curriculum support
  - **adaptation of curriculum; presentation, evaluation & assessment**
  - **advice on language development**
  - **advice on AAC***
- skills taught: feeding techniques

Support for parent
- skills taught:
  - language development
  - **AAC***

Assistive devices
(provision, maintenance, repair)
- **hearing aids**
- **communication aids**

*AAC: Alternative and augmentative communication systems

Roles of therapists (as indicated by at least 50%* of the sample)

Occupational therapy – Physiotherapy – Speech & language therapy

Activities of daily living
- feeding

Support for teacher
- information on disability

Support for parent
- Home programmes
- Information on disability

Support for community
- information on disability

Occupational therapy – Physiotherapy

Activities of daily living
- dressing

Motor function activities
- **fine motor functional activities**
- gross motor functional activities
- motor co-ordination activities
- seating positioning in classroom
- advice on seating and standing positions at home
- alternative positioning in school

Play or leisure activities
- play exploration
- sport for disabled learners
- advice on adapting & promoting physical activity to include all learners

Support for teachers
- curriculum support: physical activity

Support for parent
- information on organisations for people with disabilities

Assistive devices
(provision, maintenance, repair)
- writing aids
- feeding aids

Occupational therapy – Speech & language therapy

Support for community
- **early identification of problems**

Physiotherapy – Speech & language therapy

No overlap

Occupational therapy

Hearing/speech/ communication skills
- **visual perception skills**

Life skills/social skills
- **socialisation**

Work and productive activities
- **vocational exploration**
- **work performance preparation/ vocational training**

Play or leisure activities
- **play performance**

Support for teacher
- **curriculum support:**
  - **programmes for teachers to use with individual learners**
  - **behaviour management strategies**

Support for parent
- skills taught: behaviour management strategies

Assistive devices
- **writing aids**
- **feeding aids**

Support for environment
- adaptations in classroom

Physiotherapy

Activities of daily living
- personal device care

Play or leisure activities
- **prevention & treatment of sports injuries**
- **hydrotherapy**

Assistive devices (provision & maintenance)
- **walking aids**
- **manual & electric wheelchairs**
- **special seating**
- **standing aids**
- **advise parents in choosing assistive devices**

Support for teacher
- **information on learner's surgery**
- skills taught: lifting techniques & advice on back care

Support for parents
- **provide advice on home adaptations**
- **liaise with doctor**
- **transport learners to hospital appointments**
- information on surgery
- **advice on lifting techniques and back care for parents**

Speech & language therapy

Hearing/speech/ communication skills
- **hearing tests**
- **auditory perceptual skills**
- **language and speech skills**
- **oral-motor therapy**
- **alternative and augmentative communication systems**
- **reading and spelling remediation**

Support for teacher
- **Curriculum support:**
  - **adaptation; presentation; evaluation & assessment**
  - **advise on language development**
  - **advise on AAC**

Support for parent
- skills taught: language development

Assistive devices
- **communication aids**

*AAC: Alternative and augmentative communication systems