

**BARRIERS AND FACILITATORS THERAPISTS EXPERIENCE
REGARDING THEIR SUPPORT PROVISION IN
AN INCLUSIVE EDUCATION SYSTEM**

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A thesis submitted in partial fulfilment of the requirements for the degree of

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**UNIVERSITY of the
WESTERN CAPE**

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KEY WORDS

Inclusive education

Therapists

Barriers

Facilitators

Support services

Learners

Disabilities

Collaboration



ABSTRACT

Barriers and facilitators therapists experience regarding support provision in an inclusive education system

In South Africa, the Education White Paper 6 on Special Needs Education (2001) *Building an inclusive education and training system* stated that the special schools would be resource centres for ordinary schools that admit learners with disabilities. Occupational therapists, physiotherapists, speech and language therapists (collectively called therapists) had previously been employed in special schools, but under the new structure, would form part of the district-based support teams to provide their support to ordinary and full service schools. Therapists working in an inclusive education system would need to change the focus of their model of support from a medical model of direct support to a health-promoting model of indirect support. The aim of the current study was to determine whether therapists are changing their model of support in building inclusive and health-promoting schools and also to determine the barriers and facilitators they experience in providing their support in an inclusive education system. This study used both qualitative and quantitative methodology. The quantitative component was a non-experimental, descriptive, cross-sectional design, using one questionnaire in a survey. The questionnaire was used to determine the type of support provided to schools. In total, 97 therapists, who worked at special schools in the Western Cape, participated in the study by completing the questionnaire. The test-retest results of the questionnaire indicated that most of questions (63%) showed perfect agreement (Kappa 0.81-1.0). Quantitative data analysis was done by descriptive statistics, using SPSS. The results indicated that therapists were using the medical model of support combined with a more holistic approach using the principles of the health-promoting framework. The qualitative component involved three group interviews, which were held at three different special schools, in three different education districts, with a total of 12 therapists. The group interviews were used to determine the barriers and facilitators that either prevent or promote provision of support. Qualitative data analysis was done by using content analysis with codes and themes to determine barriers and facilitators. The barriers included the following: therapists' uncertainty about roles; lack of networking, lack of certain competencies and training; delayed response from district; lack of policy; autocratic leadership styles; exclusion from the district-based support team; concern to support learners at special school; therapists being based at the special school; lack of human resources; insufficient time; cost of therapists' training; education department circuit boundaries affecting communication;

negative attitudes of principals and educators; and parents' non-involvement. The facilitators included therapists' competencies to fulfil roles; educators' positive attitude; meetings; training to improve therapists' skills; the co-ordinating role of the district-based support team; and the supportive role of learner support educator and the principal. This study provides evidence concerning therapists' roles and the barriers and facilitators which therapists experience regarding their support provision in an inclusive education system.



DECLARATION

I hereby declare that *The barriers and facilitators that therapists experience regarding support provision in an inclusive education system* is my own work, that it has not been submitted before for any degree or examination at any other university, and that all the sources used or quoted have been indicated and acknowledged by complete references.

Signature.....

Josephine Dianne Kotze

November 2009

Witness.....

Professor P. Struthers



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I thank the Lord God Almighty, Father of our Lord Jesus Christ, who healed me of cancer. Through faith I could say: “I shall not die but live, and shall declare the works and recount the illustrious acts of the Lord” (Ps118:17). “.... I cried to You and You have healed me” (Ps 30:20).

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DEDICATION

I dedicate this thesis

To the memory of my mother-in-law, Mrs Regina Kotze, who passed away on the 11th November 2008.

To my husband, Eddy, for his love and support and for being at my side through both good and difficult times and to my children, Mignon, Adhem and Caitlin, who did not mind the takeaway foods.

To my parents, Maureen and Floris Phillips, for the important role they play in my life.




ABBREVIATIONS

| | |
|---------------------|--|
| DBST | District-based support teams |
| ED | Education District |
| EMDC | Education Management and Development Centre |
| IEP | Individualised educational programme |
| FSS | Full Service Schools |
| NCSNET/NCESS | National Commission on Special Needs in Education and Training and the National Committee on Education Support Services |
| NGO | Non-Governmental Organisation |
| SGB | School Governing Body |
| SIAS | Screening, Identification, Assessment and Support |
| Sps/ Rc | Special School Resource Centre |
| TST | Teacher Support Team |
| UNICEF | United Nations Children's Education Fund |
| WCED | Western Cape Education Department |
| WHO | World Health Organisation |

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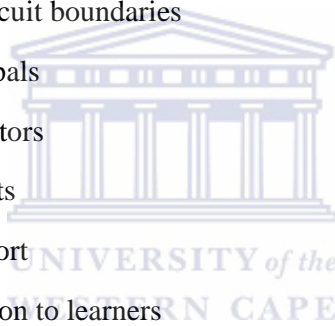
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CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

Occupational therapists, physiotherapists and speech and language therapists (referred to as therapists in this thesis) in South Africa have been employed to work in special schools and to give their support to learners, parents, and teaching and non-teaching personnel of special schools. However, since the introduction of the Education White Paper 6: Special Needs Education Building an Inclusive Education and Training System (Department of Education, 2001), therapists' roles and the ways they provide their support have been expected to change in order to support the needs of learners attending the ordinary and full service schools (Department of Education, 2001).

In the current thesis, I have explored to what extent therapists have changed their model of support and the barriers and facilitators therapists experience when giving their support in an inclusive education system.

In this chapter, the background highlights the need for the change in the model of support provided by therapists and how it can be accomplished within a health-promoting schools framework. This is followed by the problem statement, the research questions, the aim, the objectives for the study and the definition of terms. The chapter is then concluded with a summary of the different chapters.

1.2 BACKGROUND

Historically, the South African education system was divided into different departments according to race. The National Commission on Education Support Service (NCESS) and the National Committee on Special Needs in Education and Training (NCSNET) Report stated that learners with disabilities were doubly discriminated against and not allowed in ordinary schools but put in special schools and categorised according to disability/impairment (Department of Education, 1997). The realisation that exclusion from ordinary schools is a form of discrimination has caused a paradigm shift in educational thinking to accommodate learners with physical and sensory disabilities in ordinary schools (Banda, 2004). Inclusive education is aimed at including learners with disabilities and also at creating an inclusive

society. Inclusivity at educational level also facilitates inclusivity into mainstream economic and social activities (Department of Education, 2005).

In the past, most support was given to special schools for the minority white racial group, while the majority of black learners (80% of the population) were neglected (Lomofski & Lazarus, 2001). The National Education Policy Investigation of 1992 (as cited by Lomofski & Lazarus, 2001) recommended the re-organisation of education support services which would be holistic, integrated and require interdisciplinary, intersectoral collaboration between different sectors, that is, school health, social work, specialised education, vocational and general guidance, and counselling and psychological services. The re-orientation of support services refers to a major shift from a curative, problem-orientated approach to a more preventative, health-promotive and developmental approach (Department of Health, 2000). This is all necessary to redress the discrepancies of the past by providing a framework of prevention and health promotion in addition to a curative model of support (Johnson & Green, 2007).

Health promoting schools are seen as one way for the practical implementation of the inclusive education policy, using the health-promotion framework of the Ottawa Charter (Department of Health, 2000; WHO, 1986). The Jakarta Declaration (WHO, 1997) identified schools as an important venue for health promotion, providing practical opportunities for the implementation of comprehensive strategies. These strategies include building healthy public policies, creating supportive environments, developing personal skills, strengthening community action and re-orientating health services. Health-promoting schools strive to achieve healthy lifestyles for everybody in the school community, that is, learners, educational and non-educational staff and parents (Department of Health, 2000).

The Ottawa Charter recommends a shift from a curative or medical model of service delivery to a more holistic, preventative, health-promoting approach (DOH, 2000). The medical model of support, which has been used by the special schools in the past, categorised learners according to their disability or impairment (Lomofski & Lazarus, 2001). The emphasis was put on the deficit of the learner rather than on the educational needs and abilities of the learner. Interventions were mainly curative. The NCSNET/NCESS Report (Department of Education, 1997) found that the highly specialised interventions were limited to more advantaged communities in urban areas and were mainly curative. The medical model viewed

disability using a welfare/charity approach and ignored aspects such as social integration and independent living.

In 1996, the Minister of Education launched an investigation by two committees, namely, the National Commission on Special Needs in Education and Training (NCSNET) and the National Committee Education Support (NCESS) (Department of Education, 1997), on all aspects of the needs and support services in South Africa. The findings of these committees were that support provision was made for only a small percentage of learners with disabilities within special schools and classes, provision was mainly based on race, with the best resources given to the white learners, and the majority of learners with disabilities were excluded or put in ordinary classes by default. Because of an inaccessible curriculum and education system, learners with diverse needs were not accommodated, and this resulted in massive drop-out and failures. The recommendation of the NCSNET/NCESS Report was to promote an education system for all, which involves the development of inclusive and supportive centres of learning, so that all learners can develop their full potential to become equal members of society (Department of Education, 2001). The recommendations of the NCSNET/NCESS Report were used in the Education White Paper 6 (Department of Education, 2001).

According to the principles of the Education White Paper 6, support will be provided to learners with disabilities on the basis of the level and the nature of support they need and not according to their category of disability (Department of Education, 2005b). Similarly, the focus of a health-promoting support model is to determine the level of support a learner will need. It focuses holistically on learning needs and a learning environment that is free of barriers. To remove all barriers to learning, it is necessary to increase support services in the district (Department of Health, 2000, p. 11). According to the NCSNET/NCESS Report (1997), the central challenge to education was recognising and addressing the diverse needs of the entire learner population. The barriers to learning need to be identified to prevent learners from being excluded from the learning system. According to the Department of Education (2005a), one of the keys to reducing barriers to learning within all education and training lies in a strengthened education support system. Education support services can play a role by preventing, identifying and reducing barriers to learning and development. Medical, psychological, and occupational therapy, physiotherapy, and speech and language therapy form part of the education support services. Therapists, who form part of these support

services, will have to concentrate on providing support indirectly to learners, educators, family and the community (Struthers, 2005b).

According to the NCSNET/NCESS Report, not only direct service delivery of individualised specialist intervention is applicable in the new South African education system. It is clear that another way of service delivery, with the focus on prevention and development, needs to be applied. This also implies the strengthening of education support services by developing the district-based support teams, the institutional-level support teams and the special schools (Department of Education, 2005a). Special schools are being developed as resource centres to help full service schools to meet the diverse needs of all learners (Department of Education, 2005b). Therapists, being part of the resource centres, will form part of the district-based support team (Department of Education, 2005a).

The inclusion of learners with disabilities is a major challenge for full service schools. Therapists, as part of the district-based support team, must provide their support to the educators, parents, non-teaching staff and the environment, thus creating a safe and supportive environment in which teaching and learning can take place. As part of the district-based support team, therapists need to take on consultative roles to empower educators rather than giving direct support to the learners. An inclusive environment needs to be created in which all participants in the schooling community are respected and valued for their unique roles (Department of Education, 2005a). Therapists' roles in special schools have focused mainly on providing individual hands-on therapy (direct care) rather than indirect care (Struthers, 2005b). According to Struthers (2005b), therapists in special schools have used more direct support (68% of their time) and less indirect support (32% of their time).

1.3 PROBLEM STATEMENT

The NCSNET/NCESS Report (Department of Education, 1997) stated that therapists, along with others in the education support services, need to change the method of support provision to support learners in ordinary and special schools. Therapists need to change their focus of providing support in the medical model of direct support to the health-promoting model of indirect support. A need exists to explore what model of support therapists are using in the light of changes proposed by the NCSNET/NCESS Report and the Education White Paper 6 (DOE, 2001) and to describe the factors that prevent and promote therapists in giving their support to educators, learners and parents in other schools.

1.4 RESEARCH QUESTIONS

Research Question 1: Are therapists using a medical model of support or a health promoting model of support to develop an inclusive education system?

Research Question 2: What are the barriers and the facilitators experienced by therapists regarding their support provision to develop an inclusive education system?

1.5 AIM

The aim of this study is to determine whether therapists are changing their model of support in building inclusive and health-promoting schools and to describe the barriers and facilitators they experience when providing their support in an inclusive education system.

1.6 OBJECTIVES

1. To explore whether therapists are using a medical support model or a health-promoting model of support
2. To describe the barriers to therapists' support and their influence on therapists' support provision to ordinary and full service schools
3. To describe the facilitators that promote success in therapists' provision of support.

1.7 DEFINITION OF TERMS

Augmentative and alternative communication (ACC) “AAC strategies describe the way people supplement their communication when they cannot speak clearly enough to be understood by those around them. These strategies include a wide range of communication methods ranging from gestures and communication boards to assistive communication devices” (DOE, 2008, p. 3).

Barriers to learning “Refer to difficulties that arise within the education system as a whole, the learning site and/or within the learner him/herself which prevent access to learning and development for learners” (DOE, 2008, p. 3).

Category of disability “The current organiser for schools, funding and post provisioning in the special education system. These organisers have been

weighted and they include: multiple disabled, deaf, hard of hearing, blind, partially sighted, deaf/blind, cerebral palsy, specific learning disability, behavioural disorder, mild or moderate intellectual disability, severe intellectual disability, physical disability, autistic spectrum disorders, epilepsy, attention deficit disorder, with/without hyperactivity” (DOE, 2008, p. 3).

District-based support team (DBST) “Groups of departmental professionals whose responsibility it is to promote inclusive education through training, curriculum delivery, distribution of resources, identifying and addressing barriers to learning, leadership and general management” (DOE, 2008, p. 3).

Full service schools “Ordinary schools which are specially equipped to address a full range of barriers to learning in an inclusive education setting” (DOE, 2008, p. 3).

Individual support plan (ISP) “A plan designed for learners who need additional support or expanded opportunities, developed by educators in consultation with the parents, and the institutional-level support team” (DOE, 2008, p. 3).

Institution level support teams or educator support teams (ILSTs or TSTs) “Teams established by institutions in general, further and higher education, as an institution-level support mechanism whose primary function is to put in place coordinated school, learner and educator support services” (DOE, 2008, p.3).

Occupational therapy “Occupational therapy is the art and the science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life” (Townsend & Polatajko, 2007, p. 372).

Physiotherapy Physiotherapy is a “health care profession concerned with human function and movement and maximising potential. It uses physical

approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. Physiotherapy is science-based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgement and informed interpretation is at its core” (Chartered Society of Physiotherapy, 2002).

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| Special schools | “Schools equipped to deliver education to learners requiring high-intensive educational and other support either on a full-time or a part-time basis” (DOE, 2008, p. 3). |
| Special schools/resource centres | “Special schools transformed to accommodate learners who have high intensity support needs, as well as provide a range of support services to ordinary and full service schools” (DOE, 2008, p. 4). |
| Support programmes | “Support programmes refer to structured interventions delivered at school and in classrooms within specific time frames” (DOE, 2008, p. 4). |
| Speech and language therapy | “Speech-language pathology is the study of disorders that affect a person’s speech, language, cognition, voice, swallowing and the rehabilitative or corrective treatment of physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing. Speech-language pathologists or Speech and Language therapists address people’s speech production, vocal production, swallowing difficulties and language needs through speech therapy in a variety of different contexts including schools, hospitals, and through private practice” (Diehl, 2003, p. 1). |

1.8 OUTLINE OF CHAPTERS

Chapter 1 presents the background on the effect of policy changes in the educational system and how it influences the therapists’ roles of support in an inclusive education system.

Chapter 2 presents the literature review on inclusive education, which includes the legislation at international and local level, inclusive education from a human rights perspective, the

debate about terminology used in the literature, the development of education support services in South Africa, and the barriers to learning. The section on therapists in education support services focuses on different models of support, the different team approaches, therapeutic roles, and lastly, the barriers and facilitators to therapists' support provision, all of which were identified in the process of reviewing the relevant literature.

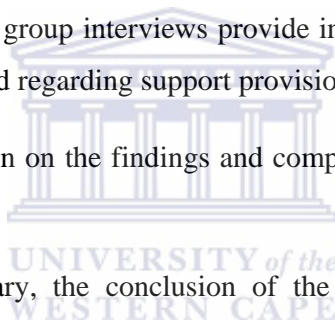
Chapter 3 presents the methodology explaining the different types of research methods used in the study. It includes the research design, the setting, the study population and sample, instruments for data collection and the reflection on data collection procedure. This chapter also contains the data collection procedure and the data analysis and concludes with the ethical issues.

Chapter 4 presents the results of the survey and the findings from the group interviews. The results of the survey include discussion on direct support, indirect support and capacity development. The results of the group interviews provide information about the barriers and facilitators therapists experienced regarding support provision.

Chapter 5 presents the discussion on the findings and compares the findings to others in the literature consulted on the topic.

Chapter 6 includes the summary, the conclusion of the thesis, and the limitations and recommendations of the study.

In the next chapter, the literature review is presented.



CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the literature on inclusive education, education support services and therapists in education support services is discussed.

2.2 INCLUSIVE EDUCATION

In this section, the literature on inclusive education from a human rights perspective, the debate about terminology used in the literature, and inclusive education internationally and in South Africa are discussed.

2.2.1 Human rights and inclusive education

At the 1994 World Conference on Special Needs Education in Salamanca, Spain, 92 governments and 25 international organisations agreed to the Salamanca Statement (UNESCO, 1994). The Salamanca Statement on special needs education (UNESCO, 1994) states that all children have a right to education, emphasising the importance of inclusive education for those with special needs. It states that schools and institutions must include all learners to celebrate differences, support learning and respond to individual needs, emphasising the principle of *education for all*. It states that regular schools with an inclusive orientation are perfect venues for fighting discriminatory attitudes, creating welcoming societies and achieving education for all. According to the Salamanca Statement, inclusive education is based on the concepts of social equity, which is consistent with the social model of disability.

The Statement recognises that the success of inclusive education lies in the provision of support services. Support services could be provided by the outreach staff of special schools, for example, advisory educators, educational psychologists, speech and language therapists, occupational therapists and physiotherapists.

After the United Nations' Convention on the Rights of Children (1989), the Jomtien World Conference on Education for All (1990) set the goal of education for all (UNESCO, 2003). At that time, programmes were targeting children and youth who were marginalised and excluded. These programmes were regarded as insufficient and inappropriate and still left

children outside the mainstream because of special programmes, specialised institutions and specialist educators (UNESCO, 1999). Delegates to the World Education Forum, convened in 2000 in Dakar, gathered to establish a development goal of providing all girls and boys with education by 2015. The principle of inclusive education was re-stated at the Dakar World Education Forum:

Inclusive education means that

“Schools should accommodate all children regardless of their physical, intellectual, social, emotional, linguistic or other conditions. This should include disabled and gifted children, street and working children, children from remote or nomadic populations, children from linguistic, ethnic or cultural minorities and children from other disadvantaged or marginalised areas or groups.” (The Salamanca Statement and Framework for Action on Special Education, UNESCO 1994, para. 3)

The United Nations has identified inclusive education as an important strategy to develop education for all (Peters, 2007). The rights of all disabled people, including those of children, have been revisited and given a new impetus with the Convention on the Rights of Persons with Disabilities (2007), which was, by 15 August 2007, signed by 101 countries (UNICEF, 2007). The United Nations’ commitment to EFA is reflected in the following statement:

“We will take all measures to ensure the full and equal enjoyment of all human rights and fundamental freedoms, including equal access to health, education and recreational services by children with disabilities and children with special needs, to ensure the recognition of their dignity, to promote their self-reliance, and to facilitate their active participation in the community.” (UNICEF, 2007, p. vi)

According to the United Nations, 80% of persons with disabilities (more than 400 million people) live in poor countries, which indicates that there is a strong link between disability and poverty. The statistics show that in developing countries, 80%-90% of persons with disabilities, of working age, are unemployed, and in industrialised countries, the unemployment rate is estimated to be between 50% and 70%. The rights to education and health are frequently denied to persons with disabilities, with 90% of children with disabilities in developing countries not going to school (United Nations, 2008).

According to the United Nations (United Nations, 2008), the year 2008 was earmarked by the Convention on the Rights of Persons with Disabilities and had as its theme “Dignity and justice for all of us”. The year 2008 was also the 60th anniversary of the Universal Declaration of Human Rights. These are legally binding instruments which set out the legal

obligations of states to promote and protect the rights of persons with disabilities. Article 28 of the Universal Declaration of Human Rights asks state parties to provide assistance for persons with disabilities, and their families, who are living in poverty, by giving adequate training, disability related expenses, counselling, financial assistance and respite care (United Nations, 2008).

The UNESCO Education for All: Global Monitoring Report (UNESCO, 2009) states that the number of children starting primary school has increased sharply since 2000 (36% in Sub-Saharan Africa and 22% in South and West Asia between 1999 and 2005) and more girls are in school than before. The report shows that 14 countries abolished primary school tuition fees, which has increased access to school for the most disadvantaged children. The report states that the number of out-of-school children dropped worldwide sharply, from 96 million in 1999 to 72 million in 2005.

The UNESCO Education for All: Global Monitoring Report (2009) states that in 2006, 513 million students worldwide were enrolled in secondary school, which is an increase of nearly 76 million since 1999. Despite this progress, 75% of sub-Saharan Africa secondary school-age children are not enrolled in secondary school. The report states that primary education is subject to public policy. Countries such as Ethiopia and Tanzania are making progress in increasing enrolment and reaching the poor because of the abolition of school fees, the construction of schools and increased educator recruitment. The progress in Nigeria and Pakistan has been held back by poor governance, which keeps millions of children out of school. Progress towards the EFA goals has been undermined by governments that failed to address inequalities based on income, gender, location, ethnicity, language and disability. In 2006, 75 million children (55% girls) were not in schools and almost half of them live in sub-Saharan Africa. Projections suggest that 29 million children will be out of school in 2015 in these countries alone (UNESCO, 2009).

The United Nations Convention on the Rights of Persons with Disabilities, which has been in force since May 2008, is the newest legal tool supporting the right of people with disabilities to education. However, children with disabilities are still amongst the most marginalised and least likely to go to school. According to UNESCO (2009), the difference in school attendance rates between children aged 6-11 with disabilities and those without disabilities, ranges from 10% points in India to almost 60% in Indonesia. This can be attributed to the

physical distance to school, layout and design of school facilities, shortages of trained educators and negative attitudes towards people with disabilities (UNESCO, 2009).

According to the South African Integrated National Disability Strategy (Office of the Deputy President, 1997), people with disabilities have been approached using the medical model of disability, according to which they were stereotyped as ill, different from non-disabled peers and in need of care. Globally, society sees people with disability from a medical and a welfare perspective. However, the disabled peoples' organisations internationally have resisted this medical model of disability and advocated for a social model of disability. The social model of disability indicates that society needs environmental restructuring to allow full access for people with disability. The main objective of the social model of disability is to provide people with disability access to full participation within society (Office of the Deputy President, 1997). Miller, Mittler, and Parker (2007) agreed that the essence of the social model of disability is that the human rights approach to disability has shifted the focus from a child's limitations arising from impairments to the barriers within the society. These barriers prevent the child from having access to basic social services, from developing to the fullest potential and from enjoying his or her rights.

2.2.2 Terminology: Integration, mainstreaming or inclusion

In this section, the debate about the terminology used in the literature concerning inclusive education is presented. Authors of the literature attach different meanings to the concepts *integration*, *mainstreaming* and *inclusion*. Distinguishing between these three terms is at times confusing, but in essence, they are used to describe the different concepts in the development of the education-inclusion process.

According to Hegarty (2004), the word *integration* was initially used as an alternative to the term *segregation*. Segregation means separate schooling, which is a special school or separate classes in ordinary schools. The integration movement started in 1960 and gained momentum through to 1970. It brought about new legislation in Italy, Denmark, the United Kingdom and the United States, which caused a move away from segregation in education (Hegarty, 2004). On the other hand, Pickles (2001), in the United Kingdom, argued that the two terms, *integration* and *inclusion*, differ completely. He suggested that inclusion values the individual as a person and enables the learner to gain access to equality and achievement (Pickles, 2001). Inclusion allows impairment and disability to be ordinary to all, that is, where the school community accepts and values diversity. Pickles (2001) and McQueen and Mackey

(1998) argued that integration means that the learner must fit into the circumstances of the school environment, whereas with inclusion, the curriculum and the culture must be adapted to accommodate the learners.

Farrell (2000) stated that, in the USA, the word *mainstreaming* was commonly used instead of *integration* and that if learners with disabilities were placed in the mainstream school, they were integrated. According to Farrell (2000), these learners experienced segregation when put in a separate class (sometimes referred to as a “unit”) in the mainstream school and when spending the whole day in isolation from other learners, even if they were placed in a class in the mainstream school. Sherrill (2006) used the term *integration* when bringing a person, who previously has been segregated, into mainstream community and school life. She concluded that integration is mainly about placement or location. According to Sherrill (2006), inclusion extends beyond location (as used in integration) to focus on services, supplementary aid, and support, enabling the greatest possible benefits from being a part of the whole.

O’Brien and Forest (2004) stated that in Canada, the word *inclusion* was first introduced in 1988, as an alternate word to *integration*, to describe the inclusion of learners with disabilities and learning difficulties into the mainstream schools. According to Farrell (2000), the term *inclusion* was introduced to describe the quality of education that learners with a disability received, as well as their active participation in the life of ordinary schools. On the other hand, Singal (2005) reported that in India, the literature on inclusive education has used the two terms, *inclusive education* and *integration*, interchangeably and synonymously without defining or distinguishing between the two different concepts; therefore, the term *inclusive education* stays an “elusive” term.

Kellegrew and Allen (1996), in the USA, made a distinction between full inclusion and mainstreamed classrooms. According to them, the mainstreamed student with a disability is placed in a special education setting and participates in a general education setting for a certain part of the classroom day. The time spent in the general classroom setting is gradually increased to full inclusion. They also stated that full inclusion is similar to mainstreaming in that the student with a disability is integrated into the general classroom (thus using the terms *mainstreaming* and *inclusion* interchangeably). This means that the classroom is the least restrictive area (LRE) and that services supporting the learner with disabilities are provided in

the most natural environment (full inclusion). Therefore, in the mainstreamed setting, the student is brought to the services (Kellegrew & Allen, 1996).

Soudien and Baxen (2006), in South Africa, stated that the objective of “mainstreaming” is to integrate learners into the existing system and support them so that they can fit in, while inclusion is recognising and respecting the differences among learners and building on their similarities. Lomofski and Lazarus (2001) also agreed that “inclusion” indicates more than just “mainstreaming” and they cite Mittler (2000), who stated that integration involves preparing pupils for placement in ordinary mainstream schools where the pupil must be able to adapt to the school. Inclusive education is based on a value system that recognises and “celebrates diversity arising from gender, nationality, race, language of origin, social background, and level of education achievement or disability” (Mittler, 2000, p. 10). According to Mittler (2000), inclusion implies a radical reform of the school in terms of the curriculum, assessment, pedagogy and grouping of pupils.

2.2.3 Inclusive education internationally

This section reviews the literature on inclusive education internationally, describing the development of inclusive education in developing and developed countries.

The authors of the literature describe a global movement towards inclusive education, that is, inclusion of all learners, regardless of race, language, culture, special learning needs or disability, into ordinary schools. According to Subban and Sharma (2006) the international developments, namely, the focus on Education for All by the Convention on the Rights of Children (United Nations, 1989), the Jomtien Declaration (UNESCO, 1990), the Dakar World Education Forum (UNESCO, 2000) and the World Summit on Children (UNESCO, 2002) showed the commitment of world leaders to increase the number of children in schools. Signatories of different countries have adjusted their national policies and practices to follow the initiatives of the United Nations, through anti-discriminating legislation that addresses inequalities and the exclusion of learners with disabilities (Subban & Sharma, 2006).

UNESCO (2003) reported that inclusive education is often difficult in the countries of the North (countries that are considered as the developed world), because of traditional policies and practices which include exclusive or segregated education for groups seen as being different or difficult or based on wealth or religion. According to UNESCO (2003), parallel

systems (mainstream - special school) still exist in many countries, especially in the northern countries, which have a mainstream education system that does not have to accommodate learners with disabilities and challenging behaviour. These countries make provision for educators to work in these specialised areas by providing incentives such as better salaries, lower retirement age and smaller classes (UNESCO, 2003). However, most of these countries have made policy and legislative changes regarding inclusive education.

According to Forlin and Forlin (1998), and Aniftos and McLuskie (2003), *Australia* has no specific legislation that mandates educational integration but has enacted anti-discriminatory legislation to protect learners with disabilities in education. This legislation includes the Education Act 1989, the Anti-Discrimination Act of 1991, the Disability Service Act of 1992 and the Disability Discriminating Act of 1992. According to Subban and Sharma (2006), the Australian federal government amended the Disability Discriminating Act of 1992 (Commonwealth of Australia, 2004), which increased the opportunities for students with disabilities to be educated in the mainstream schools.

In spite of some educators' negative attitudes towards inclusive education (Slee, 1996), Ainscow (1997) has reported evidence of significant progress towards inclusive schooling in *Australia*. According to Forlin (2004), the responsibility for special education has been moved to the different states and territories, with the national government retaining limited power. Each state has its own Education Act. There is a big variation in the degree to which inclusive education is promoted in the different states, but there are also similarities in the legislation (Forlin, 2004). Support facilities include segregated special schools, education-support centres that are frequently autonomous but on the same campus as regular schools and special educational classes within the regular school (Forlin, 2004). For example, according to Aniftos and McLuskie (2003), educational authorities in Queensland have developed policies to embrace diversity. The Board of Educator Registration (as cited by Aniftos and McLuskie, 2003) stated that the aim of educators in Queensland is to provide an inclusive education for all and to strive to redress disadvantage experienced due to differences in culture, linguistic background, gender, location, and socio-economic status.

According to Greaves (2004), *New Zealand* adopted the "mainstreaming" movement in the late 1970s and early 1980s. Special classes were disbanded, satellite classes were started in regular schools and some special schools were closed down. Kearney and Kane (2006) reported that legislation in New Zealand has protected the rights of learners with disabilities

since 1990. In 1996, policy was introduced to meet the needs of learners labelled as having “special needs”, namely Special Education 2000. Although the aim of the policy was to create an inclusive education system, the term *inclusion* was not defined in the policy, leaving an opportunity for misinterpretation and not applying it properly (Kearney & Kane, 2006). However, the New Zealand government’s aim is to achieve a world-class inclusive education system that provides equal quality of learning opportunity for all learners and students (Simmons Carlsson, 2002). According to Simmons Carlsson (2002), in New Zealand, students with special needs are seen as children first, are learners, and are a natural part of the school site. They are also members of age-appropriate general education classrooms in their regular school of attendance. The Special Education 2000 model encourages a collaborative and a consultative philosophy which implies the effective team work of all relevant role players (Greaves, 2004).

In *England and Wales*, the 1970 Education Act made local education authorities responsible for all the education of all children no matter how severely disabled. According to Farrell (2000) and Thomas and Vaughan (2004), the Warnock Committee investigated special education in 1974 and produced a report about special educational needs (Department of Education and Science, 1978). The report emphasised the concept of collaboration, stating that medical services, social services and education personnel needed to work together to meet the needs of the child and the family. Legislation over the decade of 1980s, namely the 1978 Warnock Report, the 1981 Education Act, the 1986 Disabled Persons Act and the 1986 Children’s Act, reinforced the need for more collaborative work between professionals (Lacey & Lomas, 1993). The Disability Discrimination Act of 1995 was amended to create the Special Educational Needs and Disability Act of 2001. More recent legislation that encourages schools, and further and higher education institutions to promote equality related to disability, is the Disability Discrimination Act of 2005. This was followed by the Equality Act of 2006 (Centre for Studies on Inclusive Education, 2008).

Farrell (2000) has drawn together the following conclusions from research done on inclusive education in the *United Kingdom*. First, there has been a decline of numbers of learners attending special schools in the UK. Second, academic outcomes of learners with disabilities are not clear but the learners do benefit socially from inclusive education. Third, there is little evidence of integration of learners with disabilities into ordinary schools in large numbers. Fourth, parents of learners with disabilities have different views about inclusive education.

Fifth, the attitudes of pupils and educators are generally positive towards learners with disabilities.

Inclusive education in the *United States of America* (USA) has been reported by the National Centre on Educational Restructuring in Inclusion (NCERI) as successful (Lipsky, 2004). In the USA, the Education for All Handicapped Children Act was passed in 1975 (Effgen, 2000). Several amendments of the Individuals with Disabilities Education Act (IDEA) of 1991 and 1997 led to the reauthorisation of a new Act: the Individuals with Disabilities Education Improvement Act 2004, still referred to as IDEA 2004 (Wright, 2004). According to Wright (2004), the IDEA includes two fundamental concepts. First, that all children will receive free appropriate public education in the least restrictive environment. The least restrictive environment refers to education in the natural environment, namely, the classroom. The second concept is that children with disabilities are entitled to special education and related services. Related services include occupational therapy, physiotherapy and speech and language therapy.

Peters (2007) reported that in spite of several decades of conventions and declarations regarding education, the Education for All policy documents have not resulted in significant inclusive education practice for people with disabilities, especially in developing countries. According to UNESCO (1994), in many *developing countries*, it is estimated that less than 1% of children with special educational needs are attending schools (Peters, 2007). However, according to the Education for All Global Monitoring Report (UNESCO, 2009), the average net enrolment ratios for developing countries have continued to increase since Dakar in 2000. Sub-Saharan Africa raised its average net enrolment ratio from 54% to 70% between 1999 and 2006. This shows an annual increase six times greater than during the decade before Dakar (UNESCO, 2009).

Countries of the South, or developing countries, are also referred to as income-poor countries of the world (Miles, 2009). UNESCO (2003) reported that inclusive education is hampered in the countries of the South by the shortage of resources, which includes the lack of schools or inadequate facilities, the lack of educators or a shortage of qualified staff, the lack of learning materials and the absence of support. The lack of adequate resources is preventing the successful implementation of inclusive education and many countries are dependent on external funding, for example *Lesotho* (Johnstone, 2007) and the *Caribbean* (Singal, 2005). According to Zimba, Mowes, and Naanda (2007), the lack of human and material resources

in Namibia prevents the effective implementation of inclusive education programmes. Instructional support for children with disabilities and learning disabilities has been reported as inadequate in ordinary schools.

Kashimba (2005) reported that the Zambian government is committed to reducing the number of learners in segregated, special schools and to promoting the inclusion of learners with disability in ordinary schools. According to Kashimba (2005), Zambian government policies that embrace inclusion of learners with disabilities are “Focus on Learning”, Department of Education in *Zambia* (1992) and “Educating Our Future”, Department of Education (1996). Miles (2009) reported that public education was made accessible to all in Zambia with the introduction of free basic education in 2002. Factors that prevent learners from being included are poverty, long distances between the home and school and illness. According to Moberg and Savolainen (2003), the Zambian educators and parents believe that children with severe disabilities need to be educated in special schools because it is more practical to accommodate these learners in boarding-school facilities. Inclusive education in Zambia is regarded by educators as an extension of special education using a special unit in the “mainstream school system” (Simui, 2007, as cited by Miles, 2009).

Kirstensen, Omagor-Loican, & Onen (2003) report that in *Uganda*, as in many other African countries, missionaries and other charitable organisations started special schools in the 1950s and 1960s, using models and teaching methods from Western countries. In spite of the general positive attitude amongst learners and educators in ordinary schools towards inclusive education, the survey of Kirstensen et al. (2003) showed that 79% of the respondents indicated that there was a continuing need for special schools. Among the reasons for not including children with barriers to learning and development into ordinary schools were the lack of specially trained educators in the ordinary schools, the lack of time for educators to give sufficient attention to learners with special needs, the lack of equipment and appropriate materials and a high pupil-educator ratio (Kirstensen et al., 2003). Kirstensen et al. (2006) also found that total inclusion of the learners with severe disabilities, including those who are deaf, was not possible. Respondents in this study felt that the upgrading of special schools, to act as resource centres in support of an inclusive education systems, was necessary (Kirstensen et al., 2006).

In the following section, the literature review describes the development of inclusive education in South Africa.

2.2.4 Inclusive education in South Africa

As described by Engelbrecht (2006), the *apartheid* government in South Africa ruled from 1948 to 1994 and reinforced legislation that brought about social and educational separation. At the end of 1994, the new democratically elected government inherited a fragmented education department that was based on ethnic separation and discrimination. People with disabilities were also discriminated against along racial lines as well as prevented from being educated with their peers in the ordinary schools (Engelbrecht, 2006). It was a major challenge to unite the fragmented education department under one umbrella (Stofile & Green, 2007).

According to Engelbrecht (2006) the new government was committed to ensuring the basic human rights of the marginalised groups with the adoption of the Constitution of South Africa in 1996. The Constitution of the Republic of South Africa (RSA, 1996a) as cited by Engelbrecht (2006) includes the Bill of Rights that emphasises the rights of all South Africans, regardless of race, gender, sexual orientation, disability, religion, culture or language, to basic education and access to educational institutions. Engelbrecht (2006) stated that the education policy documents and legislation such as the White Paper on Education and Training (DOE, 1995), the White Paper on an Integrated National Disability Strategy (DOE, 1997) and the South African Schools Act (RSA, 1996b) emphasise the principle of education as a basic human right, as reflected by the Constitution.

In 1996, the NCESS and NCSNET investigated the special needs and support services (DOE, 1997). The report's recommendations were taken up in the Education White Paper 6 on Special Needs Education: Building an Inclusive Education and Training System of 2001 (DOE, 2001), which recommends major changes in the education system. These changes include the development of full service schools, special schools acting as resource centres to neighbouring schools, and the establishment of district-based support teams (DOE, 2001). Full service schools are proposed to accommodate learners with a full range of learning needs (DOE, 2005a). The report of NCSNET and NCESS (DOE, 1997) provides a broad framework for full service schools, which is, firstly, about an ethos of inclusiveness for all learners, and, secondly, about the development of full service schools that must have the capacity to accommodate diversity, and, thirdly, about the adaptation of learning programmes in mainstream education institutions.

The Education White Paper 6 on Special Needs Education: Building an Inclusive Education and Training (2001) states that special schools, acting as resource centres, will have a special relationship with full service schools in terms of interchange of knowledge, skills information and technical skills (DOE, 2005a). Full service schools are ordinary schools that will be equipped to address the learning needs for learners who require moderate to high levels of support alongside learners with ordinary support needs (Swart, 2004). This policy also implies that personnel from special schools/resource centres will be drawn into the district-based support teams to form part of the education support services (DOE, 2005a).

2.3 EDUCATION SUPPORT SERVICES (ESS)

In this section, literature on education support services (ESS), the barriers to learning and the development of education support services is discussed.

The Salamanca Statement states that “the provision of support services is of paramount importance for the success of inclusive educational policies” (UNESCO, 1994, p. 31). The strengthening of the ESS is a key factor in reducing barriers to learning within all education and training (DOE, 2001; UNESCO, 1994; DOE, 2005a). Evidence from research also indicates that the success of inclusive education depends heavily on the availability and expertise of support in class (Farrell, 2000).

Inclusive education is about meeting the diverse needs of learners within the ordinary classroom (UNESCO, 1994). In order to meet these needs, adequate support for the educator needs to be available (Engelbrecht, Green, Naiker, & Engelbrecht, 1999). Support can be from parents, children, rehabilitation workers, professionals, colleagues, organisations for disabled people, families and/or the wider communities (Hawwash, 1998). To ensure the successful implementation of inclusive education, the Salamanca Statement recommends that external support is provided by resource personnel from various agencies, departments and institutions. These resource personnel include advisory educators, educational psychologists, speech and occupational therapists and physiotherapists (UNESCO, 1994).

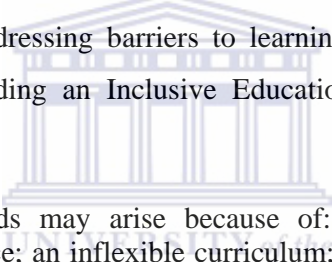
For example, in Australia, Prigg (2002) reported that guidelines provided by the New South Wales Department of School Education state that an interdisciplinary support team is necessary in assisting the child with disability and its family in the transition from pre-school to mainstream school. Therapists are described as advisers to the team. Therapists are employed by the New South Wales Department of Community Service, and the Department

of Health, to support learners with disabilities from 12 months before school begins until the end of their first year in school (Prigg, 2002). However, educators also find support from institution-based educator support teams (TSTs) which can assist them with difficulties when teaching learners with disabilities (Daniels & Norwich, 2001).

In South Africa, the NCSNET/NCESS report recommends that the ESS must move away from only supporting individual learners to supporting the educators, so that barriers of learning can be identified, minimised and removed (DOE, 1997). The following section provides a discussion regarding the barriers to learning and education support services in South Africa.

2.3.1 Barriers to learning

Barriers to learning are factors that hinder teaching and learning (DOE, 2005a). According to Engelbrecht (2006), the report of NCSNET and NCESS emphasised the need for a systemic approach in identifying and addressing barriers to learning. Education White Paper 6 on Special Needs Education: Building an Inclusive Education and Training System (2001) identified that



“different learning needs may arise because of: negative attitudes and stereotyping of difference; an inflexible curriculum; inappropriate languages or language of learning teaching; inappropriate communication; inaccessible and unsafe built environments; inappropriate and inadequate support services; inadequate policies and legislation; the non-recognition and the non-involvement of parents; inadequately and inappropriately trained education managers and educators”. (DOE, 2001, p. 18)

According to the Department of Education (2005a), factors that affect learning can be related to the individual, the curriculum, the physical and psychosocial environment, the home environment and, lastly, factors in the community and social dynamics. Barriers to learning related to the individual refer to the learner and the educator. In the learner, barriers relate to specific learning needs and styles. Personal factors, teaching approaches and attitudes of the educator might create barriers to learning and teaching (DOE, 2005a; Lomofski & Lazarus, 2001).

According to the Department of Education (2005a), different aspects of the curriculum that may act as barriers to learning include factors such as content, language or medium of instruction, the organisation and management in the classroom, the methods and processes used in teaching, the pace of teaching and time available, the learning materials and

equipment, and the assessment procedures. UNESCO (2003) reported that the curriculum has been unable to meet the needs of a wide range of different learners. In 1996, in Mpumalanga province, high repetition rates were common, and 23% of black learners aged between 15 and 19 did not pass Standard 4, while only 1% of white learners for the same age group did not pass Standard 4 (UNESCO, 2003). This can be attributed to teaching and learning that takes place through a language which is not the first language of many South Africans, as well as a curriculum that cannot accommodate the needs of learners (UNESCO, 2003).

Factors which act as barriers to learning in the learner's home environment include issues such as family dynamics, cultural factors and socio-economic status (DOE, 2005a). According to UNESCO (2003), socio-economic factors that place learners at risk are unemployment, poverty, HIV/AIDS, violence and abuse. Community and social dynamics can either support or hinder the teaching and learning process (DOE, 2005a).

The DOE (2005a) also pointed out that barriers to learning may occur relating to the physical and psychosocial environment within which teaching and learning takes place. These can also include buildings as well as management styles (DOE, 2005a). According to Lazarus, Daniels, & Engelbrecht (1999), physical environmental barriers can occur in the form of inaccessibility in terms of the building structures, the classrooms and the equipment. Structural barriers in the environment include inaccessible toilets and entrances, awkward steps and stairs, and problematic interior designs (for example, fixed seats and limited floor space). The school environment may not be safe, especially in the light of violence and gangsterism (Lazarus et al., 1999). Learners with physical disabilities in Swedish and in Canadian schools (Hemmingson & Borell, 2002; Pivik, McComas, & Laflamme, 2002) reported unmet needs such as absence of ramps, elevator problems, seating problems and missing assistive devices. Routine changing of classrooms creates its own problems, such as carrying books, the use of personal computer equipment or assistive devices (Hemmingson & Borell, 2002; Pivik et al., 2002).

According to the Education White Paper 6 on Special Needs Education: Building an Inclusive Education and Training System (2001), strategies need to be put in place to remove these barriers to learning in order to prevent learners from being excluded from the curriculum and the education and training system. This will require early identification of needs to provide adequate and appropriate support. The Education White Paper 6 (2001) acknowledges that the key to reducing barriers to learning lies in strengthened education

support services. In the next section, the literature on the education support services in South Africa is discussed.

2.3.2 Education support services in South Africa

According to the Department of Health (2000), the education support services (ESS) consist of sectors of school health, social work, psychology, special education and guidance and counselling services. The functions of ESS in the past were mainly geared to cure learners with special educational needs, rather than to prevent learning difficulties or barriers to learning, and to focus on health promotion. Traditionally, the medical model was used to support learners who failed to make academic progress in a mainstream classroom (Johnson & Green, 2007). It was believed that the deficit was in the learner and it could be remedied by specialised interventions such as occupational therapy, speech and language therapy or the input of a medical specialist.

According to Lomofski and Lazarus (2001), education support services in South Africa have been neglected in the past, especially for the majority of the black population, which has experienced gross marginalisation, either in special or mainstream schools, due to racial inequality in general education. NEPI and Donald (as cited by Lomofski & Lazarus, 2001) reported that 40-50% of black learners with special educational needs had been mainstreamed without the necessary support to accommodate these learners. This means that in the past, educators have had to cope with learners with a multitude of diverse learning needs and mostly without support (Lomofski et al., as cited by Lomofski & Lazarus, 2001). According to Engelbrecht, Eloff, & Newmark, (1997), this left educators with negative feelings, such as helplessness, because support provided to them was inadequate and they felt a need for regular meetings to share anxieties, fears, ideas, and educator-learning strategies.

The NCSNET/NCESS Report (DOE, 1997) acknowledged that alternative ways of service delivery focusing on prevention and development are necessary for a unified South African education system. The NCSNET/NCESS Report (DOE, 1997) promoted a two-prong and three-tier support system for schools and other educational institutions. The two-prong approach is, firstly, about transformation of the institution and curriculum development, in a preventative and health-promoting way, in order to address the diverse needs of learners with barriers to learning and development. Secondly, it is about additional support learners will need that is provided by other specialists, for example, therapists, counselling support and career guidance. The Commission (DOE, 1997) recommended the development of a three-

tier support system that includes the development of a support team at institutional level, the establishment of district support teams and the development of competencies of provincial and national administrations to address barriers to learning and promote effective teaching and learning.

According to Lazarus et al. (1999), these principles indicate an integrated approach that involves all relevant resources to understand and address these barriers, as well as a community-based approach drawing on local and indigenous resources to provide support. This includes professional support services from district teams and other departments such as health and welfare. Effective intersectoral collaboration at district and site level is necessary in order to understand the problems and challenges and to bring about comprehensive responses to these. Support services have been non-existent, especially in rural and historically disadvantaged areas, and, if they do occur, they are often fragmented and uncoordinated. Different service providers work individually, and a holistic, integrated approach is necessary to develop a framework for collaboration and teamwork (DOE, 2005a).

The White Paper on Education and Training (DOE, 1995) acknowledged the fact that a holistic and integrated approach to education support services needs to be explored in collaboration with the provincial Ministries of Education and in consultation with the Ministries of Health, Welfare and Population Development and Labour. The inclusive integrated approach recognises that issues of health, social, psychological, academic and vocational development and support services for learners with special educational needs in the mainstream schools are all inter-related (DOE, 1995).

The South African policy proposes that in an inclusive education system, education support services consist of district-based support teams (DBST) and institution-level support teams (DOE, 2005a). The function of the DBST is to build capacity and support educational institutions to recognise and address learning difficulties. By doing this, the DBST empowers these institutions to accommodate learners with a range of learning needs (Johnson & Green, 2007). It is expected of these teams to provide specialised learner and educator support, curricular and institutional development and administrator support in both the classroom and the organisation. The main focus of the DBST is to provide indirect support or “consultancy” to learners through supporting the educators and school management (DOE, 2005a). The DBST is expected to consist of staff from special schools, which are converted to resource centres, and staff from provincial, district and regional offices (Johnson & Green, 2007).

Due to the inadequacy of the ESS, a new model was proposed around the principle of holistic development, which refers to a broad health promotion and developmental approach, with prevention as a strategy to decrease the need for extensive curative interventions. A re-orientation of support services was necessary to replace the focus on individual assessments and move towards interventions, which focused more on collaboration with educators (Fay 2003; Johnson & Green, 2007).

2.4 THERAPISTS IN EDUCATION SUPPORT SERVICES

In this section, the literature on therapists in education support services is discussed, including direct and indirect support, the models of support, the support team approaches, therapeutic roles, and the barriers and facilitators therapists experience when providing their support.

The literature indicates that therapists in many countries have had to change their model of support as legislation changed and moved towards inclusive education (Effgen, 2000; Eger, 1992; McEwen, 1995; Pollock & Stewart, 1998; Jirikowic, Stika-Monson, Knight, Hutchinson, & Washington, 2001; Law, Lindsay, Peacey, Gascoigne, & Soloff, 2002). Therapists had to change their support to a more educational focus or a social model of support (Swinth & Hanft, 2002). Three different models of support were identified in the literature, namely, direct support, monitoring and collaborative consultation (Dunn, 1988, 1990; McEwen, 1995; King, McDougall, Tucker, & Gritzan, 1999). Dunn (1990), Sandler (1997) and Sekerak, Kirkpatrick, Nelson, and Propes (2003) found that therapists use a combination of service delivery options and distinguish between traditional “pull-out” model (direct therapy), integrated therapy and consultation. In the following sections, the different models of support provision are discussed.

2.4.1 Direct and indirect support

Direct support originates from the medical model, where the deficit is found in the learner and the intervention is used to cure rather than to prevent (Pollock & Stewart, 1998). Direct support is most frequently used by many therapists and involves the direct interaction with the individual learner (Dunn, 1990; Rapport, 2002; Struthers, 2005b). In this model, the therapists identify the problem, create an individual plan and provide the intervention as specified (Dunn, 1990).

According to Jirikowic et al. (2001), direct support is the primary model of service delivery used in hospitals, outpatient and home-based settings. Due to therapists' training, this model is most often used in schools (Dunn, 1990; Jirikowic et al., 2001). Globally, therapists have been trained to identify impairments within the learner and then to find an appropriate remedy by treating or managing these impairments (Dunn, 1990; Struthers & Lewis, 2004). However, therapists have been criticised for focusing on achieving therapeutic rather than educational goals (Dunn, 1990; Niehues, Bundy, Mattingly, & Lawlor, 1991; Royeen, 1986; Struthers, 2005b). Therapists need to set goals for interventions that are clearly related to educational outcomes (Royeen & Marsh, 1988). This implies that therapists need to move away from a focus on the direct support for individual learners to mainly providing indirect support for all learners through the therapists' support for educators and parents (Struthers, 2005b).

In order to provide direct support, the pull-out model or one-to-one intervention is used (Swinth & Hanft, 2002). In the United Kingdom, speech and language therapists have traditionally used the "pull out" model (that is an integral part of the medical model) but have changed to models of consultancy because learners miss out on important curricular information (Law et al., 2002). Rapport (2002) reported that physiotherapists also make use of the pull-out model to provide direct therapy. Dunn (1990) and Sandler (1997) suggested that the best practice model is to use both direct therapy and consultation. According to Swinth and Hanft (2002), a national survey (in the USA) indicated that the majority of occupational therapists working in school settings use the two service models with almost equal frequency. Changes in legislation in the USA, the UK, and Australia mandated therapists to change their mode of delivering their support and become part of a collaborative team (Lacey & Lomas, 1993; Prigg, 2002; Rapport, 2002; Simmons Carlsson, 2006).

According to Struthers and Lewis (2004), for many South African tertiary training institutions, the medical model is still the focus and foundation of training. In South Africa, Struthers (2005b) investigated education support services provided by occupational therapists, physiotherapists and speech-language therapists in the Western Cape Province. The results show that therapists provide both direct and indirect support, overlapping of support by different disciplines occurs and that multidisciplinary collaboration and teamwork are poorly developed. Struthers (2005b) indicated that therapists provided more direct support (68%) than indirect support (32%).

Indirect support is the support therapists provide to learners through support for parents and educators or support for changing the environment. According to Bundy (1995), the therapist teaches a procedure to the educator, aide or the parent and therefore needs good teaching skills. With the implementation of inclusive education in South Africa, therapists need to adjust their support by identifying and addressing barriers to learning and development in the system (Struthers, 2005b). Therapists need to work with the school community, the environment, the educators and the parents to minimise or remove barriers to learning and development (Struthers, 2005b).

According to Struthers (2005b), therapists will need different skills to provide indirect support. Since therapists need to work with educators, they need skills for collaboration. Struthers (2005b) also found that educators realised that they need maximum support to be able to identify barriers to learning, to identify the support learners need, and to address the barriers to learning. On the other hand, therapists maintained that their support to educators needed to focus on support for access to the curriculum (Struthers, 2005b).

2.4.2 Models of support

Kaminker, Chiarello, O'Neil, and Dichter (2004) defined indirect services as monitoring (once or twice per year) and consultation (about once per month). In the following sections, the different models of support, namely, the monitoring and the consultative models, are discussed.

2.4.2.1 Monitoring

Although the monitoring model is seen as an indirect support service, it contains elements of direct support since the therapist first needs to assess the learners to identify their needs and then plan the intervention in order to teach the educators or parents. Monitoring in itself is an indirect support service in that the therapist monitors the learner's progress and how the person is performing the procedure (Effgen, 2000; Dunn, 1988). According to Dunn (1988), the most critical feature of monitoring is to identify an educational need that will be best supported by routine and consistent procedures needing ongoing guidance and practice. Activities of daily living, positioning and handling, reach and grasp, fine motor skill development, or co-ordination needs might be best supported through monitoring (Dunn, 1988).

The monitoring model needs diagnostic skills to identify the learner's needs, to plan programmes, to design the relevant interventions, to teach and to supervise so that others can implement the programme or intervention (Dunn, 1988). This involves constant provision of information and evaluation of the progress between the child and the intervention agency, for example, the educator or classroom assistant (Hartas, 2004; Lindsay, Doctrell, Mackie, & Letchford, 2005). According to Dunn (1988), the therapist still remains responsible for the outcomes and needs to continue regular contact with the learner and intervention agency to see if any adjustments need to be made.

The therapist/educator relationship in the monitoring model differs from that of the consultative model, in that the responsibility of the outcome is shared in the consultative model, but the therapist maintains responsibility in the monitoring model. This means that the relationship between the therapists and the educators is hierarchical, and the partnership is not equal, because the therapist must evaluate if the intervention is properly done (Bundy, 1995).

2.4.2.2 Consultative model

The consultative model is related to indirect support service. According to Lacey and Lomas (1993), indirect support is provided when the specialist is giving advice and information to the class educator. The therapist may also interact with other adults so they can carry out the intervention appropriately (Rapport, 2002). According to Effgen (2000), the therapist's contact may be with the entire educational team, including the parent and the child. The activities will then be done by all personnel except the therapist, and therapy occurs in the learning environment (Effgen, 2000). According to Dunn (1988), the consultation model uses specialised expertise to facilitate the workings of the education system, for example, developing the most effective environment for students and consulting with other colleagues to improve their skills and knowledge.

The consultation model mainly involves indirect intervention to achieve common goals (between stakeholders), which differs from the monitoring model, where the therapist determines the goal of treatment (Hartas, 2004; Law et al., 2002). The immediate goal of consultation is to solve a current problem, which results in a shared problem-solving process, and the long-term goal is to enable the person seeking advice to handle the problem skilfully in the future (Dunn, 1988). The consultation model, however, still suggests that there is inequality in partnership since an expert is providing advice (Hartas, 2004; Law et al., 2002).

Therapists' roles in giving support to educators have been emphasised in the literature (McQueen & Mackey, 1998; Sandler, 1997). As stated by Mahon and Cusack (2002): "Physiotherapists, as experts in movement and in treating children with cerebral palsy, are ideal professionals to be involved in the preparation of educators for inclusive education" (p. 596), implying that physiotherapists can give indirect support to learners by training and supporting educators to work in an inclusive education system. Speech and language therapists have traditionally used the "pull out" model that is an integral part of the medical model, but have changed to models of consultancy (Hartas, 2004; Lindsay et al., 2005). Hemmingson and Borell (2002) emphasised the importance of support to educators by health professionals to change and adjust the physical environment at Swedish mainstream schools, because of their knowledge about how to compensate for disabilities.

Research done by Sandler and Evans-Rogers in 1990 (as cited by Sandler, 1997) led them to argue that although direct therapy is needed by some learners with a physical disability, one may use the consultative model under conditions of limited resources. Occupational therapists in the school system in the USA have at times been faced with large numbers of learners and were consequently expected to provide their support by consultation and monitoring rather than using direct support (Exner, 1987, as cited by Sandler, 1997).

As with monitoring, the consultative model is based on the therapist doing one-to-one assessments and designing intervention programmes which are then implemented by educators and parents. The basis of this approach is continuing therapeutic input by people with constant contact with learners with physical disabilities (Hartas, 2004). Sandler (1997) posed the question that even if educators do receive sufficient training, do they have the time to implement the programme and is there enough consultative input from therapists? The success of the consultative model depends on the expertise, knowledge and skills of educators who teach learners with disabilities.

The authors of the literature consulted reported that schools that aim to develop support services which allow for professional interaction and share knowledge among disciplines are most likely to have positive outcomes with inclusivity (Creese, Daniels, & Norwich, 1997; Farrell, 2000; Jones, 1997). Educators reported that non-teaching classroom support, visiting professionals and in-service training are important factors that determine the success or failure of integrated therapy and inclusive education (McQueen & Mackey, 1998). Aniftos and McLuskie (2003) reported that educators are considered as the key to change in

education. Most educators welcome the support provided by therapists and other educators in educator support teams (Creese et al., 1997; Farrell, 2000; Jones, 1997).

In the following section, the different support team approaches namely the multidisciplinary, interdisciplinary and the collaborative team approaches are discussed.

2.4.3 Support team approaches

The literature uses various terms to describe groups of professionals working together, namely, multidisciplinary teams, interdisciplinary teams, and collaborative teams (Lacey & Lomas, 1993; McQueen & Mackey, 1998).

2.4.3.1 The multidisciplinary team approach

In the multidisciplinary approach, each professional acts independently, using the withdrawal of learners (McQueen & Mackey, 1998; Rapport, 2002). Each expert brings his or her knowledge to the client and does assessments individually, as in the medical model. Information is sent to one member of the team, and a group decision is not made as to the best procedures to be followed (Lacey & Lomas, 1993). This can cause conflicting results or recommendations if the implications of these recommendations are lost due to lack of knowledge or expertise. In the multidisciplinary model, professionals work in isolation, without collaboration amongst them to make joint decisions regarding the implementation of recommendations or teaching approaches or to determine resources that are required (Lacey & Lomas, 1993).

2.4.3.2 The interdisciplinary approach

In order to overcome fragmentation caused by the multidisciplinary approach, the interdisciplinary approach promotes group meetings to discuss recommendations (Lacey & Lomas, 1993). This approach has been described by McQueen and Mackey (1998) as partial collaboration between professionals, since assessment and intervention remain discipline specific.

According to Lacey and Lomas (1993), the following difficulties or barriers exist with both the multidisciplinary and the interdisciplinary approaches: there is a lack of follow up with regards to recommendations; there is a lack of regular contact with the learner; the class educator who must implement all the recommendations may have no resources, the least authority and feel the least able; and recommendations usually include the type of programme

but do not specify the amount of support given to the educator in order to implement the programme.

2.4.3.3 Collaborative approach

Collaborative consultation has been described by Dunn (1988) as an equal partnership between two individuals to identify, plan and carry out recommendations. Collaboration means joint planning, decision making and problem solving directed toward a common goal which results in effectively meeting the diverse needs of learners and better protection of right of the child (Lacey & Lomas, 1993).

Engelbrecht, Eloff, Forlin, and Swart (2001) argued that professional support personnel need to see themselves both as collaborators and as consultants. Hartas (2004), in a study in the UK, described collaboration as collegial, interdependent and co-equal styles of interaction between educators and speech-language therapists. The term *collaboration* has been used to describe the interprofessional relationship between therapists and educators (Wright & Graham, 1997). The use of an individual education plan (IEP) has been suggested by Pickles (2001) to be a common mode of communication tool for collaboration between all services and the ideal place for the implementation, as collaboration needs to take place in the classroom setting.

A study done by O'Toole and Kirkpatrick (2007) showed that interdisciplinary training contributes positively to collaboration between health and education sectors. In this study, participants (educators, occupational therapists, physiotherapists, and psychologists) felt more confident in their ability to identify speech and language difficulties of children and implement communication goals after a training programme. However, although participants were equipped to assess and implement language activities in the classroom, the general feeling was that it was still the responsibility of the speech and language therapists to do the direct intervention. Nevertheless, participants in the study were generally positive regarding collaborative working practices (O'Toole & Kirkpatrick, 2007). In the collaborative relationship, each profession contributes existing skills and knowledge to the classroom, but also gains new skills and knowledge (Tollerfield, 2003). According to Effgen (2000), the collaborative model is defined as a combination of the transdisciplinary team approach and integrated service delivery. The transdisciplinary approach is similar to the consultative model, with exchange of knowledge and skills taking place across professional boundaries (Chapman & Ware, 1999; Sandler, 1997).

Integrated therapy is a term used in the fields of education and disability to indicate the type of approach used to apply therapy in a functional way in the everyday life of the learner and the family, including at school, where learners are spending a significant part of their lives (McQueen & Mackey, 1998). Likewise, according to Sekerak et al. (2003), integrated service delivery is defined as therapy occurring within the educational context that involves the daily routines in the classroom along with classmates and educators.

According to Sekerak et al. (2003), the success of the integration of therapy services in the classroom depends heavily on the relationships between educators, physical therapists, parents and other professionals. The relationship with educators is described as the foundation for successful integration. This relationship is characterised by collaboration, co-operation, communication and support (Sekerak et al., 2003). An integrated approach ensures a holistic method, with functional activities, and can be achieved if disciplines move away from multidisciplinary or interdisciplinary work to a more collaborative approach (McQueen & Mackey, 1998).

Since 1970 in the UK and 1975 in the USA, legislation about inclusive education mandated therapists to become involved in a relationship of collaboration with other disciplines (Effgen, 2000). This has caused therapists to reconsider the different ways of effective service delivery in an inclusive system (McEwen, 1995; Niehues, et al., 1991; Rapport, 2002). In the USA, therapists, as part of related services (education support services), were needed to help with the successful integration of learners with disabilities (Rapport, 2002). According to USA legislation, all children with disabilities are entitled to related services, for example, occupational therapy, physiotherapy and speech and language therapy (Effgen, 2000; Wright, 2004). This concept mandates for a partnership with other professionals in a multidisciplinary team, which calls for communication and collaboration to deliver an effective service to children with disabilities (Effgen, 2000).

In the UK, the Warnock Report and the subsequent legislation specified that learners with special educational needs will need support from various services to ensure successful integration (Lacey & Lomas, 1993). These laws emphasise that close working relationships between professionals in different services are essential to unite fragmented advisory services in England (Lacey & Lomas, 1993). Likewise, in New Zealand, the philosophy of Special Education 2000 also underpins collaboration among various sectors (Simmons Carlsson, 2002).

In the following section, the different therapeutic roles are described.

2.4.4 Therapeutic roles

Therapists such as occupational therapists, physiotherapists and speech and language therapists have been identified as important personnel that play vital roles in support provision in an inclusive education system (York, Giangreco, Vandercook, & Macdonald, 1992).

Assessments and intervention are two of the primary roles of occupational therapists and physiotherapists working in the public schools to achieve functional outcomes (Bundy, 1995; Dreiling & Bundy, 2003; King et al., 1999). This includes the setting of goals and planning of intervention and determining the setting where intervention is about to take place.

Physiotherapy has been described as a related service provider that focuses on skills that are necessary to achieve independent motor control and movement (Rapport, 2002). York et al. (1992) stated that support personnel need to focus, more than in the past, on environmental adjustments and improvements, instead of focusing on fitting a student into the existing environment. The role of occupational therapists and physical therapists overlaps in terms of functional use of hands, mobility and transition, posture (body alignment) and physical activity and fitness (York et al., 1992). School systems in the USA recognise physical therapy as a related service that can help the child explore the environment, perform activities of daily living, improve function in schools, prepare for vocational training and improve physical fitness. This is all essential to prepare learners for life after school and to ensure independent living and economical self-sufficiency (Effgen, 2000).

The occupational therapists' goal in a school environment is to improve learners' ability to perform the tasks and activities necessary for school functioning (Whalen, 2003). Direct intervention may be necessary to improve, restore, and maintain the skills necessary for functioning in the school environment or prevent them from getting worse. In order to match the learners' skills and abilities and the expectations placed on them in the school setting, consultation and education of adults in the learners' homes and school environment may be necessary. Occupational therapists use task adapters, task modifiers and assistive devices to optimise the learners' performance in the school setting (Whalen, 2003). Occupational therapists are also involved in advising educators on alternate teaching strategies after assessing the barriers to learning experienced by learners (Dunn, 1991).

According to Wright and Graham (1997), speech and language therapists play a vital role in the development of communication. This involves the assessment, planning and treatment in all areas of speech and language with learners who have lost these skills due to injury or trauma. Speech and language form the basis for learning and reading. Wright and Graham (1997) found that successful communication between the speech and language therapist and the educator is of vital importance to allow learners with speech and language difficulties access to the curriculum. Speech and language therapists provide information and evaluate the progress between the child and the intervention agency. The intervention agency can be the educator or classroom assistant (Hartas, 2004; Lindsay et al., 2005).

In South Africa, Struthers (2005b) reported that therapists, as part of education support services, can play an important role by giving holistic support (direct and indirect support) by using the health-promoting schools framework. This includes the five different components of the Ottawa Charter: develop healthy policy, develop a healthy physical and psychosocial environment, empower the community, develop personal skills, and re-orient the support services.

a) According to Struthers (2005b), therapists can play an important role in developing healthy school policy by serving on school governing bodies or forming partnerships with community organisations for people with disabilities to develop provincial or national policies. Healthy school policies may include developing a safe and accessible environment inside and outside the school.

b) Therapists can play a role in developing a safe and supportive teaching and learning environment by installing rails and ramps and adapting toilet seats and basins inside the school and on the playgrounds (Struthers, 2005b).

c) Therapists can play a role in building school-community networks and partnerships. Struthers (2005b) found that educators identified therapists as important in the development of the links between the educators and the parents, making intersectoral links between the health and education sectors and creating links with organisations for people with disabilities.

d) Therapists can play a role in developing the personal skills of all in the school community including the learners, educators, non-teaching personnel, parents and families. Struthers (2005b) found that only a few therapists were involved in the development of personal skills

of educators and parents. Most therapists were involved in the development of learners' skills through direct support, which was not integrated into the curriculum.

e) Struthers (2005b) suggested that the re-orientation of education support services to a health-promoting approach is necessary to focus on identifying and addressing barriers to learning. Therapists need to re-orient their indirect support services to mainly indirect support by including these four components of the health-promoting schools framework.

In the following section, the barriers and facilitators experienced by therapists that are identified in the literature are discussed.

2.4.5 Barriers and facilitators

Analysis of the literature assists in identifying barriers and facilitators that therapists experience in their collaborative relationship with educators and other key role players, when providing their support in the inclusive classroom (McCartney, 1999).

2.4.5.1 Barriers

Just as the implementation of inclusive education has faced many barriers, therapists have also experienced many challenges and obstacles preventing successful provision of service delivery (Giangreco, 1995; Prigg, 2002).

McCartney (1999) reported that some of these challenges may lie in the form of barriers that threaten a collaboration relationship at different levels of support provision. Difficulties with collaboration can cause a barrier to therapists' support provision to ordinary schools. Wright and Graham (1997) found that the area of joint working (collaboration) between educators and speech and language therapists is usually in the area of intervention rather than in assessment and planning. The different areas of joint working can be attributed to different perspectives on defining and meeting needs. However, different professions may have different goals, which can cause conflict rather than collaboration. In contrast to Wright and Graham's (1997) findings, Kersner and Wright (1996) found that the highest levels of collaboration are concentrated on assessment and planning rather than during intervention in a special school setting. According to Kersner and Wright (1996), the setting in the special school is ideal to allow collaboration between educators and therapists because of its separate nature that produces a "forced interaction". Wright and Graham (1997) ascribed

successful collaboration to the well-defined roles that each profession has in the special school.

Communication problems can be an inherent barrier to collaborative work, as described by Wright and Kersner (2004), when different employment agencies are involved, such as the Departments of Education and Health and because the different professionals use different terminology. The difficulty with availability of staff at the same time, and the demands outside the project that were placed on staff by education and health services, were also factors that cause barriers (Wright & Kersner, 2004; O'Toole & Kirkpatrick, 2007).

As the classes in special schools are smaller than in the ordinary schools, time may be a major constraint for educators in ordinary schools who have to liaise with members of a multidisciplinary team (Wright & Kersner, 1999). Chapman and Ware (1999) also reported that time acts as a major constraint in teambuilding. Jirikowic et al. (2001) indicated that heavy caseloads of therapists limit time available to provide direct support. Most educators and speech and language therapists in the UK perceive time commitment/constraints as barriers in their collaborative workings with one another (Law et al., 2002).

The lack of human resources creates a barrier to the support provision of therapists. Sandler and Rogers (as cited by Sandler, 1997), found that educators reported a lack of adequate physiotherapy and occupational therapy input in different therapeutic and functional activities, which can be the result of an overly large learner/therapist ratio. Examination of the literature shows that speech and language therapists also experience a shortage of human resources based in the classroom (Law et al., 2002; Pollock & Stewart, 1998).

The consultative model can present challenges. As Hartas (2004) reported, educators interviewed in his study saw speech and language therapists as a threat in their classrooms. The educators indicated that speech and language therapists had a perception that they were professionals and the only ones who had answers because the learners' problems were in the speech and language domain. This resulted in an unequal relationship, affecting the partnership between the professional groups. On the other hand, therapists perceived educators' negative attitudes, especially their unwillingness to give up power in the classroom, as a barrier to their support delivery (Hartas, 2004). Other barriers to the collaborative relationship between educators and speech and language therapists included changes in staffing and shifting of responsibilities that did not encourage the development of relationships and effective channels of communication, poor understanding of role

descriptions, poor management, lack of clear policy statements and the lack of stability in terms of staffing, resources and physical arrangements (Hartas, 2004).

Therapists' lack of teamwork skills and training responsibilities were reported by Giangreco (1995). Physiotherapists' training at entry level (in the USA) provides limited preparation for employment in a school-based setting, since the curricula do not emphasise paediatrics, which is included in post-graduate studies. This leads to a shortage of qualified physiotherapists who are able to work in the school setting (Prigg, 2002; Rapport, 2002).

Chapman and Ware (1999) reported that the fear of abandoning professional roles and responsibilities is a challenge to the collaboration relationship. Wright and Kersner, (as cited by Baxter, Brookes, Bianchi, Hay, & Rashid, 2009), indicated that speech and language therapists could feel threatened by passing on their knowledge to educators, fearing that they may no longer be needed. Group work can lead to conflict and indecision as the different role players may have different assessment and treatment goals (Chapman & Ware, 1999).

According to Struthers (2005b), South African school-based therapists do not know how to act as consultant-mentors and, to maintain equality in the power balance in their relationship with the educators in the classroom, this is important for successful collaboration. Therapists are struggling to change their belief that barriers of learning are only within the learner, towards the understanding that support needs to be given to the educator. Struthers (2005b) reported that only some therapists clearly understood their roles within the curriculum and knew how to work with the appropriate skills and knowledge within the curriculum. This is because therapists were not often considered or included at pre-service and in-service training provided by the Department of Education. Therapists indicated that they do not receive support from the school management and the educators to use new models of support. Therapists still need to change their focus on rehabilitation to support for educational outcomes. School management, educators, learners and parents need to understand the changing roles of the therapists (Struthers & Lewis, 2004).

2.4.5.2 Facilitators

Benefits of collaboration can act as facilitating factors that promote therapists' support provision to other schools. These benefits include sharing of expertise, gaining a holistic view of the learner, the increase of each professional's own knowledge base, a decrease of stress levels, and gaining more realistic expectations of one another (Chapman & Ware,

1999; Wright & Kersner, 2004). Through collaboration, educators and therapists can take newly gained knowledge, ideas and therapy into the classroom and learn from one another (Tollerfield, 2003). Other supportive factors of collaboration are the willingness to make professional changes and to learn from one another, making an individual contribution, and having shared values and beliefs (Chapman & Ware, 1999). The collaborative relationship between health and education professionals can have an affect on the communication with the parents. If there is communication and collaboration taking place regarding learners' assessment, planning and intervention, parents will receive less confusing reports from professionals (Elkens, Van Kraayenoord, & Jobling, 2003).

Tollerfield (2003) found that one of the factors that helped to overcome barriers in the collaborative relationship between educators and speech and language therapists was therapists being considered as part of the school and not seen as visitors. Social relationships and friendships, with mutual respect for one another's skills and knowledge, could develop, which is an important element for collaboration. Because the different professionals have different goals, joint objective setting was used to combine both components. Therapists and educators also made attempts to share terminology and agree on its meaning. The learners' speech and language needs were also addressed throughout the school day and not only in the speech and language therapy sessions (Tollerfield, 2003).

2.5 SUMMARY

In this chapter, the literature on inclusive education and legislation at international and local level has been reviewed. Inclusive education was discussed from a human rights perspective and included the section on the concepts related to inclusive education. This was followed by the development of education of support services in South Africa and the barriers to learning. The section on therapists in the education support services focused on the support used by therapists. The two main models of support, namely direct and indirect support, were discussed, focusing on the medical model and the health-promoting model of support. From these models flow the mode of operation by the different disciplines, ranging from the multidisciplinary to the interdisciplinary and collaborative approaches. The barriers and facilitators were discussed, including the difficulties related to the collaborative relationship, which is vital for the success of therapists' provision of support.

In Chapter Three the methodology used in the study is presented.

CHAPTER THREE

METHODOLOGY

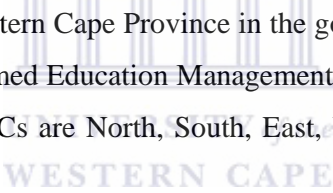
3.1 INTRODUCTION

In this chapter, the research design and the setting in which the study took place are described. A description of the study population, methods and instruments for data collection is given. The chapter includes the data collection procedure and the data analysis, and finally, the ethical considerations are discussed.

3.2 RESEARCH DESIGN

Quantitative and qualitative methods were used. The quantitative method used a non-experimental, cross-sectional, descriptive design in a survey. Qualitative procedures included three group interviews.

3.3 RESEARCH SETTING

This study took place in the Western Cape Province in the government special schools. There are seven education districts, named Education Management District Centres (EMDCs) in the Western Cape. The seven EMDCs are North, South, East, West, Central, West Coast/Wine lands and the South Cape/Karoo. 

3.4. STUDY POPULATION AND STUDY SAMPLE

3.4.1 Study population

The study population included therapists, that is, occupational therapists, physiotherapists, and speech and language therapists, based in government special schools (except for two speech and language therapists based at EMDC level) in all the EMDCs in the Western Cape Province.

3.4.2 Inclusion and exclusion criteria

Therapists employed by the Western Cape Education Department and those in the School Governing Body posts at the special schools could take part in the study. In addition, two therapists based at an EMDC office also participated in this study because they were the only therapists employed at that level. Therapists in hospital schools, schools of skills, schools of safety and youth care centres, Mathematical and Science Centres and sports schools were

excluded for reasons of convenience. All the remaining 41 special schools were included after comparing lists obtained from the WCED website, EMDC Metropole East and a Nu Thera list from one of the therapists working at one of the special schools. The researcher accidentally thought that two schools, namely St Josephs and the Carel du Toit Centre were private schools and excluded them from the study.

3.4.3 Sample

3.4.3.1 Survey

The sample for the survey included 117 therapists, (60 occupational therapists, 26 physiotherapists, and 31 speech and language therapists) working at special schools in the Western Cape. Schools from the list (Section 3.4.2) were contacted telephonically, and the number of therapists interested in participating in the study was confirmed. Everybody at the special schools was interested.

3.4.3.2. Group interviews

Purposive sampling was used for the three group interviews. According to Skinner (2007) a focus group should consist between six and ten members. On the other hand, Kitzinger (1995) stated that the ideal focus group size is between four and eight people. Because the groups of this study consisted of five, three and four therapists respectively, the focus groups as originally planned became group interviews. Fourteen therapists were selected, of whom 12 people (seven occupational therapists, three physiotherapists and two speech and language therapists) participated. When I distributed the questionnaire during the survey, I met a number of therapists, especially those in charge. Informal discussions with therapists in charge led to the choice of participants for the group interviews. This was based on therapists' knowledge of inclusive education, experience working at special schools and willingness to share information. The group interviews were held in three different EMDCs, in three different schools. Therapists in each group interview were based at the same school.

- Group interview 1: (5 participants) two occupational therapists; one speech and language therapist; two physiotherapists
- Group interview 2: (3 participants) three occupational therapists
- Group interview 3: (4 participants) two occupational therapists; one physiotherapist; one speech and language therapist

3.5. QUESTIONNAIRE

Data were collected by means of a self-administered questionnaire (Appendix 1) in the survey. The main purposes were, firstly, to determine the type of support (direct or indirect support) provided by therapists and secondly, to explore if therapists are using the medical model of support or the health-promoting model of support (Objective 1).

3.5.1 Development of questionnaire

The questionnaire that was used was compiled, developed and piloted by Struthers (2005b). This questionnaire was developed to investigate the type of support therapists were giving to learners. According to Struthers (2005b), the questionnaire was based on the components of the health-promoting framework, including the development of healthy school policy, the development of a healthy school environment, the development of links with the community, the development of personal skills and the re-orientation of the education support services.

The questionnaire was divided in three sections, namely, the direct learner support, the indirect learner support and the capacity development of therapists. This will enable Objective 1 to determine model of support used by therapists.

The first section was about direct learner support. Direct learner support refers to individual time spent with the learners doing assessments, providing treatment and evaluating the intervention. The questions were therefore directed at assessments of learners, the reasons for assessments and the site/place of assessments. Questions established whether there were other professional personnel at their workplace, the inclusion of other role players when deciding on learners' support needs and therapists' goals, the type of direct learner support provided, and the inclusion of other role players when evaluating direct support. Questions also determined whether therapists evaluated their direct support and if they referred learners to other therapists in state hospital and in private practice. Possible reasons for non-referrals were also included.

The second section was about the indirect support therapists provided, by giving their support to educators, non-teaching personnel and parents. Learners were also indirectly supported by facilitating an accessible environment and an appropriate curriculum and support in the community. Questions in this section determined if curricular support was given to assist educators, if support was given to educators in groups or individually, and if support for educators related to ergonomics and kinetic handling. Questions on support to parents

included development of their knowledge and skills, support in their homes, advocacy and emotional support.

The third section contained questions on how the capacity of therapists was developed, as well as the role they played in the development of the capacity of others, namely, teaching, medical, nursing and therapy students over the previous year. This included capacity development through training, supervision and mentoring.

The questionnaire contained closed-ended questions that allowed the participant to tick the relevant answer. In analysis, it was assumed that if a space was left blank, the answer would be “no”. Some of the questions used a Likert-type scale including a choice of “always, sometimes or never” and “often, sometimes or never”.

3.5.2 Reliability

The reliability had not been established by Struthers, so prior to the pilot study the reliability of questionnaire was determined by test-retest study.

The reliability of the questionnaire was tested by doing a test-retest study. According to Trochim (2006b), it is impossible to calculate reliability accurately. That is why it is necessary to estimate reliability. This estimation was done using the test-retest method. In this study, therapists were requested to complete the questionnaire and then repeat the exercise again after an interval of 2 weeks. The critical aspect of this estimation is the time factor between the two measures. The shorter the gap, the higher the correlation or agreement of answers. Where the gap is longer, the correlation will be lower (Trochim, 2006b).

The sample included 16 participants. The test was done at two schools. After permission to conduct the study had been obtained from WCED (Appendix 2), a letter containing information regarding this procedure was delivered by hand to their school principals and the two therapists in charge (Appendices 3 & 4). The whole process was also explained to the therapists in charge. In spite of comments that it would be a very long questionnaire, people were prepared to take part in the test-retest. The time taken to complete the questionnaire varied from 30 to 45 minutes.

The scale for Kappa agreement was used to measure the percentage of the summary agreement before and after the self-assessment of the set of questions (Fleis, 1981). The Kappa agreement uses the following scale: fair agreement is 0.2-0.4, moderate agreement is

0.41-0.6, substantial agreement is 0.61-0.8, and perfect agreement is more than 0.8 (See Appendix 5 for detailed results of the test-retest).

Of all questions answered 63% had a correspondence of more than 80% percent (Kappa 0.8), which showed a “perfect agreement”, whereas 28% of all questions answered showed a substantial agreement (Kappa 0.61-0.80). A moderate agreement (Kappa 0.41-0.60) was displayed by 9% of all questions (i.e., 5 questions) answered. No questions answered fell in the fair agreement (Kappa 0.20-0.40) category.

The five questions (9%) that showed a moderate agreement (Kappa 0.41-0.60) had a correspondence of less than 60%.

1. Question 19 showed a correspondence of 53% (Kappa 0.53). This question was about therapists’ frequency of evaluation of direct support, the frequency of assessment procedures, and whether therapists considered that the goal was achieved within the proposed timeframe. The therapists could not give consistent answers to the different sections of this question.

2. Question 25 showed a correspondence of 50% (Kappa 0.50). This question was about therapists’ individual or group support to educators. This question made use of a Likert-type scale, asking if individual or group support was given often, sometimes, or never to educators at special schools, ordinary schools, educator support teams at the schools and educators at the EMDCs. Therapists were inconsistent in providing their answers to the question about their support to educators.

3. Question 35 showed a correspondence of 54% (Kappa 0.54). This question was about the support that therapists provided to learners in ordinary schools. Support to learners in ordinary schools included providing information on disability, information on the rights of people with disability, information on inclusion and whether therapists are involved with learners from the ordinary school visiting the therapy department at the special school. Therapists were inconsistent in answering the question about therapists’ support to learners in the ordinary school.

4. Question 38 showed an agreement of 42% (Kappa 0.42) and showed a moderate agreement (Kappa 0.41-0.60). This question was about the therapists’ involvement in the development of the curriculum. This included adaptation of curricular content, developing alternate ways of presenting the curriculum and developing alternate ways of assessing learners. The therapists were inconsistent in answering the question about therapists’ involvement in

developing the curriculum. This may imply that therapists are not sure about the role they play regarding the curriculum.

5. Question 49 showed an agreement of 46% (Kappa 0.46). The question was about the proportion of time therapists currently spend in terms of direct and indirect care and how they would like to spend it in future. The implication of this inconsistency might be that therapists did not understand the question and interpreted it wrongly. This question requested therapists to reply in percentages which did not add up to 100%.

These questions were not removed from the questionnaire because the aim was not to change the quantitative measuring instrument but to measure the reliability of the answers to the questions. However, the reliability of these answers will be considered in the discussion.

In conclusion, this questionnaire proved to have strong reliability because the majority of the questions (63%) showed perfect agreement (Kappa 0.81-1.0). Of the total, 28% presented substantial agreement (Kappa 0.61-0.80), 9% showed moderate agreement (Kappa 0.41-0.60), and there was no fair agreement (Kappa 0.21-0.40).

3.5.3 Validity

Validity refers to the question of whether an instrument is measuring what it is supposed to measure (Babbie & Mouton, 2006). Because the instrument had already been given to the experts in the field to comment on (to ensure content validity) and used by Struthers, there was no intention to change the questionnaire. Struthers (2005b) discussed the content with occupational therapists, physiotherapists and speech and language therapists working in the field, who suggested it had good content validity.

Verbal feedback from therapists who completed the first part of test-retest in general was that they felt the questions were clear and relatively easy to answer (Section 3.5.1). External validity and the extent to which the results can be generalised to the whole schooling community of South Africa would be difficult to assess since there are more special schools in the Cape Metropole than in some other parts of the country. This might influence the kind of support therapists can provide, especially in the rural areas.

3.6 PROCEDURE

Details about ethical consideration are found in Section 3.8.

3.6.1 Survey

Therapists in charge at each school were contacted telephonically to discuss the study and also to determine any interest in participating in this study. All therapists contacted were keen to participate. When interest and the number of therapists were established, questionnaires with a cover letter (Appendix 6) were sent to each participant. Where there was more than one therapist at a school, the questionnaires were sent in a batch and addressed to the head of department. The cover letter contained the information and procedures regarding the research study. Outside the Cape Metropole, 18 questionnaires were posted to 14 schools. A pre-paid, stamped envelope for each person was also included. Forms that contained the request for participants' written consent (Appendix 7) were also included with each questionnaire. Furthermore, 99 questionnaires were delivered by hand to therapists at special schools in the Cape Metropole. The questionnaires were collected from the therapists in charge at a later date.

The questionnaire was used in Struthers' (2005b) study, which was conducted in 2001 by interviewing therapists working in special schools in the Western Cape. The same questionnaire was used in the current study and was completed in 2008. Comparisons of the findings of Struthers' (2005b) study and this study were done to see if there has been a change in the model of support used by therapists.

3.6.2 Group interviews

Three group interviews, with a total of 12 therapists, were held in three different schools, to obtain qualitative data from therapists in EMDC North, South and East. According to Babbie and Mouton (2006), group interviews are the most effective way to gain access to data from different individuals in a limited period of time. The purpose of the group interviews was to meet Objectives 2 and 3, namely, to describe the barriers and facilitators therapists experience when providing their support to ordinary schools.

Participants were asked to read the information sheet (Appendix 8) explaining the study, confidentiality and anonymity. Therapists were requested to give permission to be audio taped, which they agreed to. An explanation was given to the therapists about the research,

and they subsequently filled in a consent form confirming that they agreed to participate voluntarily and at any stage could withdraw from the study. A scribe accompanied the researcher to take notes, and information was also put on newsprint so that it could be visible to the participants.

3.6.2.1 Interview guide

An interview guide (Appendix 9) was used for the group interviews. Open-ended questions were used to promote discussion, for example, “What problems do you experience when you go into the ordinary schools?” Questions were not always asked in the exact sequence laid out in the interview guide, but the researcher facilitated the conversation by probing to learn more.

Participants were initially put at ease with questions about their work environment, which included information about the learners they are working with, their work experience and the school setting. Secondly, it was then established how therapists provide their support to ordinary schools. Therapists were then encouraged to share their experiences in providing their support. This included the barriers that prevent them from giving adequate support and the facilitators that promote support provision. Lastly, the support to therapists that enabled them to be involved in inclusive education was discussed.

3.6.2.2 Trustworthiness

According to Lincoln and Guba (1990), trustworthiness has different aspects, namely, credibility, dependability, transferability and confirmability. Credibility is about how true the interpretation of data is, as perceived by the participants, on the one hand, and the realities, on the other hand (Babbie & Mouton, 2006). To ensure the credibility of the data from the group interviews, the recorded interviews were transcribed and a copy was sent to the therapists in charge at each of the relevant schools to verify the contents. Therapists at the three schools were invited to do the necessary corrections and return copies. No corrections were made and coding was started. Coding was done by both the researcher and the supervisor. The supervisor reviewed the transcripts and coding. Quotations of the participants’ views (from the transcribed text) were also used to increase credibility (Graneheim & Lundman, 2004).

Dependability means that if the study were to be repeated in the same circumstances with the same participants, its findings would be similar (Babbie & Mouton, 2006). If this study were to be repeated with the same therapists in the same schools of the Western Cape, the findings

of barriers and facilitators that therapists experience are likely to be the same, provided there has not been a major change in the support provision. This implies dependability. According to Lincoln and Guba (1990), if a study has credibility, dependability of the study is already established.

Transferability is the extent to which the findings can be transferred to other settings or groups (Babbie & Mouton, 2006). However, it is not possible to apply the findings to another context in qualitative research unless a clear, distinct description of culture and context, selection and characteristics of participants, data collection and process analysis is given (Graneheim & Lundman, 2004). Since a detailed description was given of this study, a similar study can be done in a different setting. If the context and the characteristics of the participants are similar, then the findings will be similar.

According to Shenton (2004), the concept of confirmability should be the qualitative researcher's comparable concern to objectivity used in quantitative methods. A reflective commentary should be kept to explain the researcher's own predisposition (Shenton, 2004). After each group interview, a reflective journal was written to ensure objectivity when recording and analysing the results and participation in the discussion. A scribe accompanied the researcher, which made it easy to confirm data that were not audible enough on the recording. Due to the poor quality of the sound on the tape recorder, it sometimes became necessary to confirm information with the notes taken by the scribe. Information was summarised and put on newsprint by the researcher or an assistant so that it could be visible to the participants.

3.7 REFLECTION ON DATA COLLECTION PROCEDURE

I worked as a physiotherapist for 19 years in a clinical setting in private and in government hospitals. Coming from a completely different background, I found that doing research in the education field was a total change of scenery. The desire to do research and the challenge to do something completely different became appealing to me in 2007. The only experience I had had with inclusive education was when attending an exposition about inclusivity, called Access, at the International Convention Centre in Cape Town in 2004. I then had my doubts about inclusive education in mainstream schools and did not think it would be practically feasible. However, the research has convinced me otherwise.

On reflection, on collecting data, most principals were keen to help me and would refer me to the therapist in charge. Only one principal was abrupt and would not give me a minute of her time. However, after several attempts involving e-mails, a fax, and contacting the deputy principal, I contacted the therapist and made an appointment to discuss the research and give her the questionnaire. According to the ethical procedures, permission from the principal was needed, but the deputy principal gave permission.

However, all the therapists were generally very friendly and accommodating in spite of very tight schedules. I first phoned them to establish their interest in the study. I then made an appointment to discuss and deliver the questionnaire. After the first meeting, I would make another appointment, within two weeks, to collect the questionnaire. However, I was surprised at how easily therapists accepted me although I was not working in their environment. I had the feeling that because I was an outsider, therapists perceived me as being objective and not part of the system, which allowed them to confide in me easily. One of the therapist's remarks confirmed this later on: "Why didn't we think of doing this research since we are working in the situation? I guess we are too busy and maybe too much emotion will go into it. It's best somebody from outside is doing it."

While delivering the questionnaires and conducting the group interviews, I visited 27 schools in the Cape Metropole. During these visits, therapists were keen to share their experiences. They also used the opportunity to vent their frustrations about the problems they experienced. With these informal meetings and the group interviews, I had the feeling that therapists wanted me to be their voice outside their area of specialisation.

With my first group interview, I must admit that I felt inexperienced. As the discussion progressed, I realised that the therapists had limited experience of how to give their support to ordinary schools. I felt awkward when one therapist started asking me questions because of her lack of knowledge. I was disillusioned when I discovered that not all therapists at special schools knew about their supportive role to ordinary schools. On the other hand, the therapists in the other two group interviews were experienced and knew what was expected of them regarding their support provision in an inclusive education system. However, I realised that conducting and facilitating the group interviews was a good learning experience as I became more relaxed and confident during the second and the group interviews.

The second group interview left me with a sense of powerlessness. I could detect a sense of despondency when we were discussing the issue of people in power (the principal) who

would not allow therapists to participate in community projects. Policy and red tape had been used to impede therapists if they wanted to go out to ordinary schools. I experienced a feeling of people held captive in a prison by the principal, who abused his power by suppressing the therapists. These therapists were passionate about their work and knew exactly what their supportive roles to the ordinary school were supposed to be. Because they felt that there was nothing to stimulate them, they had given up fighting and wanted to leave the school.

I would like to describe the third group as the success story of inclusive education, although the therapists had also met with barriers of a different kind. They had started reaching out on their own initiative to an ordinary school when the government was too slow to react to their request for a full service school that they could visit. However, a full service school was later allocated to them.

Although I felt that more group interviews in other EMDCs could have been done, time was limited. Although it would have been interesting to see what their barriers and facilitators were, I doubt that the results would have been different.

3.8 DATA ANALYSIS

3.8.1 Survey

Quantitative data analysis was done using descriptive statistics by means of percentages, proportions and ratios, using the Statistical Package for Social Science (SPSS). Descriptive statistics, using cross tabulations, were used to present the therapists' data according to each professional group. Tables, graphs and summaries were then created. These results can be found in Chapter Four.

3.8.2 Group interviews

All group interviews were conducted in English. Afrikaans was seldom used. Therapists would use Afrikaans interjections or phrases if they could not remember the English expressions immediately. The Afrikaans sections were translated into English by the researcher, who is bilingual. Discussions in group interviews were transcribed and repeatedly read to find recurring concepts. These concepts were coded and put together to form categories (Babbie & Mouton, 2006; Graneheim & Lundman, 2004). Themes that emerged from these categories in answer to the objectives are as follow:

- Barriers and facilitators related to therapists' roles

- Barriers and facilitators related to intrinsic factors
- Barriers and facilitators related to extrinsic factors
- Barriers and facilitators related to the DBST
- Barriers and facilitators related to the principals
- Barriers and facilitators related to relationships with the educators
- Barriers and facilitators related to relationships with the parents.

3.9. ETHICAL CONSIDERATIONS

Approval was obtained from the Senate Higher Degrees Committee of the University of the Western Cape and ethical permission was granted by the Senate Research Grant and Study Leave Committee of the University of Western Cape (UWC) to conduct this study. Permission to conduct this study was obtained from the Western Cape Education Department (Appendix 2). Principals of special schools were contacted telephonically, e-mailed, and faxed, and letters (Appendix 5) were sent to them to obtain permission to conduct this research. The principals were informed about the research and procedures to be followed.

3.9.1 Survey participants

The therapists and the relevant key role players were invited to complete the questionnaire after reading the participant information sheet and giving their written consent. Although therapists were ensured of their anonymity, some of them preferred to put their names on the questionnaire.

3.9.2 Group interview participants

Participants in the group interviews were provided with an information sheet (Appendix 8) that contained information on the study. Therapists gave written consent to be audio taped in the interview and were informed that audiotapes were to be stored in a locked filing cabinet and would be destroyed when the study was completed.

Participants could at any stage withdraw from the study. Confidentiality was maintained throughout the research process. No harm to participants was intended and no risk was involved in this study.

3.10 SUMMARY

The population and sample, research design and methods used in this study have been discussed. The research design used quantitative methods in a non-experimental, cross-sectional, descriptive study and used a survey with a questionnaire, and qualitative methods were used with group interviews. The questionnaire was handed to or sent to therapists working in the special schools of the Western Cape. Three group interviews were held at three different special schools with therapists, in three different EMDCs. The questionnaire was explained and the reliability and validity of the questionnaire were discussed. The trustworthiness of the qualitative data was also discussed. The different procedures of collecting data, recording and analysis were described. The ethical considerations were also described.

In Chapter Four, the results of the study are presented.



CHAPTER FOUR

RESULTS

4.1 INTRODUCTION

In this chapter, the findings related to the objectives, as set out in the first chapter, are presented. Findings in Section A are related to Objective 1. Objective 1 was to explore whether therapists are working in a medical model of support or in a health-promoting model of support. Findings in Section B are related to Objectives 2 and 3. Objectives 2 and 3 were to describe the barriers and facilitators that therapists experience in providing their support in an inclusive education system.

4.2 SECTION A: RESULTS OF SURVEY

In this section, the results of the questionnaire are presented. This section of the results is divided into direct support, indirect support and capacity development of therapists and their roles in building capacity of others.

In total, 117 questionnaires were distributed and 97 therapists responded. Although the response rate was 83% (N=97), not all therapists answered all the questions and the maximum response to questions was n= 96. The different disciplines in the sample are displayed in Table 4.1.

Table 4.1 Demographic data of therapists (n=96)

| Discipline | n | % |
|-------------------------------|----------|----------|
| Occupational therapist | 46 | 48% |
| Physiotherapist | 25 | 26% |
| Speech and language therapist | 25 | 26% |
| Total | 96 | 100% |

Table 4.2 presents the therapists' current employment.

Table 4.2: Therapists' current employment (n=96)

| | OT | PT | SLT | Total |
|---|-----------|-----------|------------|--------------|
| | n=46 | n=25 | n=25 | n=96 |
| | % | % | % | % |
| Western Cape Education Department (WCED) post | 94 | 88 | 84 | 89 |
| School governing body (SGB) post | 8 | 12 | 16 | 11 |
| Also in Private Practice | 2 | 4 | 8 | 4 |

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

A total of 89% of therapists (n=85) were employed by the Western Cape Education Department (WCED), 11% by the school governing body (n=11), and 4% of therapists who were employed by the school were also in private practice (n=4), (see Table 4.2).

Direct learner support is presented in Section 4.2.1 and indirect learner support in Section 4.2.2.

4.2.1 Direct learner support

This section includes the assessment of learners, the treatment, intervention or management given or needed, evaluation of the treatment, the setting where therapists worked and the referrals outside the school. Table 4.3 presents the findings about the different settings therapists were using when providing their support.

Table 4.3 Therapists using different settings for treating learners (n=96)

Figures that are in bold indicate 50% and more.

| | Frequency | OT n=46 % | PT n=25 % | SLT n=25 % |
|---------------------------|--------------|-----------------|-----------------|------------------|
| Classroom | often | 47 | 14 | 44 |
| | occasionally | 51 | 86 | 56 |
| | never | 3 | 0 | 0 |
| School therapy department | often | 91 | 100 | 96 |
| | occasionally | 9 | 0 | 4 |
| | never | 0 | 0 | 0 |
| Alternative room | often | 20 | 21 | 50 |
| | occasionally | 63 | 64 | 25 |
| | never | 17 | 14 | 25 |
| School playground | often | 27 | 27 | 0 |
| | occasionally | 68 | 68 | 54 |
| | never | 6 | 5 | 46 |
| Private practice | often | 0 | 29 | 8 |
| | occasionally | 12 | 14 | 8 |
| | never | 88 | 57 | 85 |
| Learner's home | often | 0 | 0 | 0 |
| | occasionally | 37 | 71 | 8 |
| | never | 63 | 29 | 92 |

OT = Occupational therapist, PT=Physiotherapist, SLT= Speech and language therapist

All therapists indicated that they were using direct support. The majority of therapists often used the school therapy department. Most therapists occasionally used the classroom and the school playground. Most occupational therapists and physiotherapists occasionally used an alternate room. Only a small proportion of therapists saw learners in private practice. Most physiotherapists indicated working occasionally at the learner's home.

Table 4.4 presents the findings relating to the frequency with which therapists provided their individual or group treatment to learners.

Table 4.4 Therapists providing individual or group treatment (n=95)

Figures that are bold indicate 50% and more.

| Individual/ group treatment | Frequency of treatment | OT | PT | SLT |
|--------------------------------|--------------------------------------|-----------|-----------|-----------|
| | | n=45 | n=25 | n=25 |
| | | % | % | % |
| Individual learners | Often worked with individuals | 69 | 92 | 96 |
| | Occasionally worked with individuals | 31 | 8 | 4 |
| Groups of learners | Often worked with groups | 91 | 64 | 75 |
| | Occasionally worked with groups | 9 | 36 | 25 |

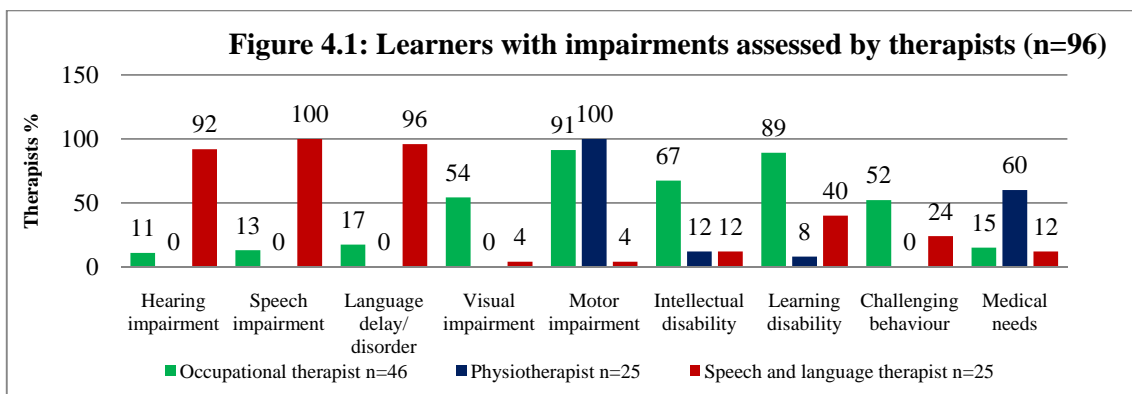
OT = occupational therapist, PT = physiotherapist, SLT = speech and language therapist

Most therapists often worked with individuals as well as with groups of learners. More physiotherapists and speech and language therapists were working with individual learners than working in groups. More occupational therapists were involved in therapy in groups than working individually with learners.

4.2.1.1 Assessment

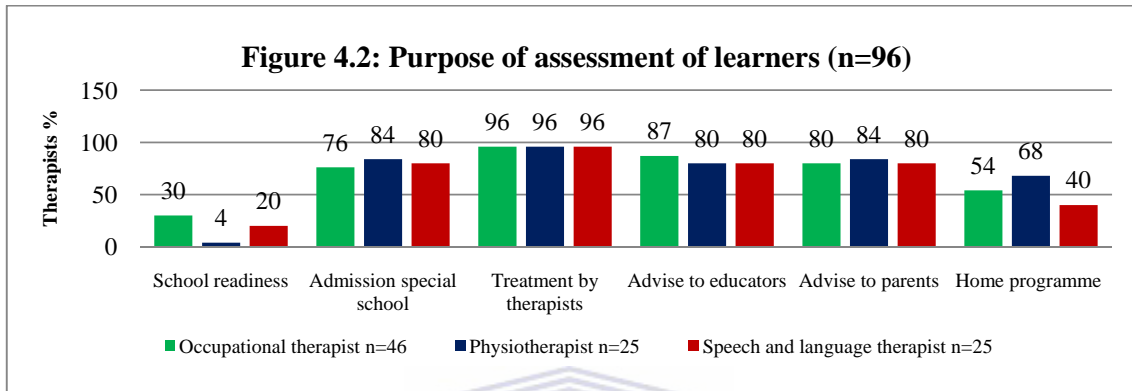
Figure 4.1 indicates that therapists of all three disciplines were involved in assessment of learners with a variety of impairments or disabilities.

Figure 4.1 presents the findings of therapists when assessing learners with impairments.



Occupational therapists were mainly involved in assessing learners with motor, intellectual and learning disabilities. Physiotherapists assessed learners with motor impairments and medical needs. Most speech and language therapists assessed learners with hearing, speech and language disorders.

Figure 4.2 presents the purpose of the assessment of learners.

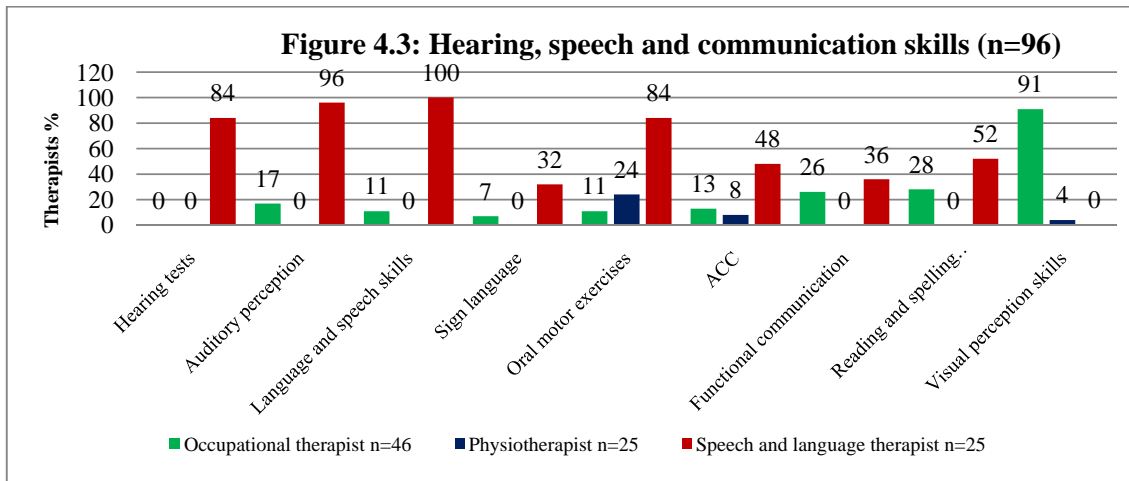


The majority of therapists reported that they were assessing learners for admission to special schools and treatment by therapists and giving advice to educators and advice to parents. Most occupational therapists and physiotherapists assessed learners to provide home programmes. A small percentage of occupational and speech and language therapists assessed learners for school readiness.

4.2.1.2 Intervention, management and treatment

Direct support includes developing hearing, speech and communication skills, activities of daily living, life or social skills, home management skills, work and productive activities, motor functioning skills, and play and leisure activities. Therapists were focused on developing these skills when providing direct support. The results are shown in Figures 4.3-4.9.

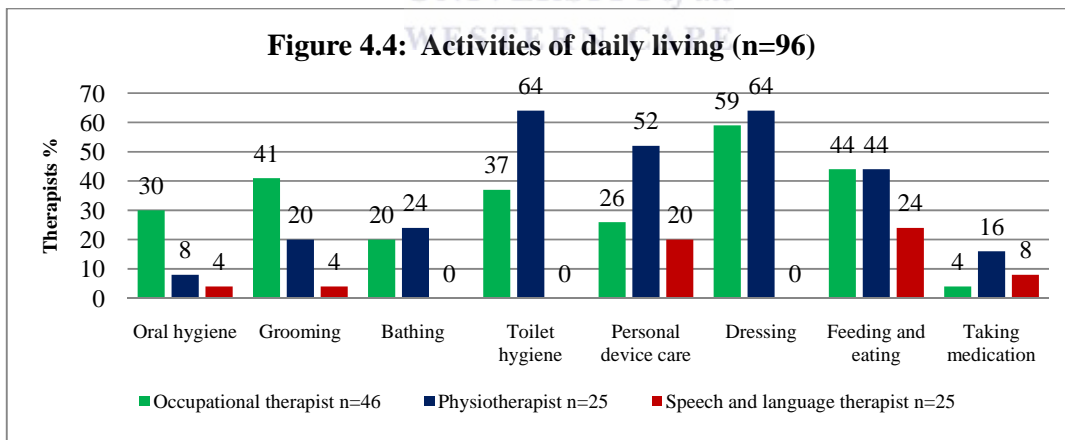
Figure 4.3 presents the findings on therapists regarding developing hearing, speech and communication skills.



ACC= Alternative and augmentative communication

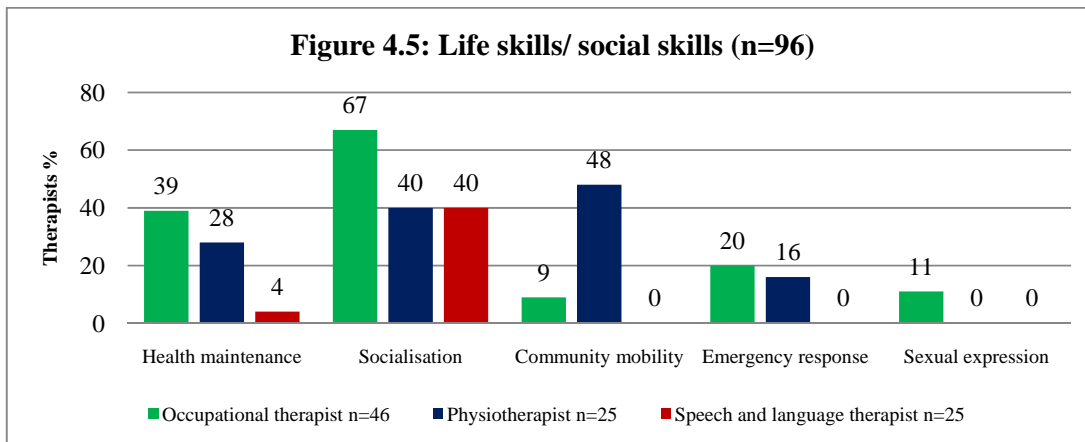
Most speech and language therapists were providing direct support to develop the learners' hearing, speech and communication skills as well as oral motor, reading and spelling skills. Occupational therapists were focused on developing visual perception skills.

Figure 4.4 presents the findings of therapists concerning developing activities of daily living.



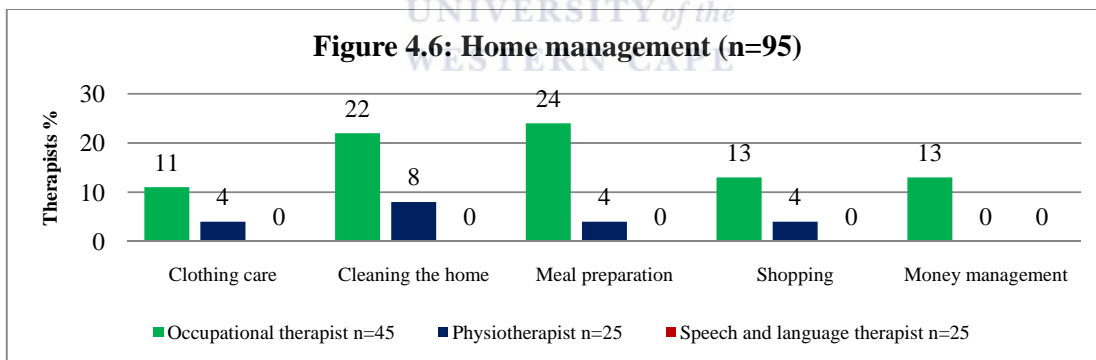
Most occupational and physiotherapists were involved in developing skills in the activities of daily living. Most physiotherapists developed dressing, personal device care and toilet hygiene skills. Most occupational therapists developed dressing skills and some provided grooming and toilet hygiene skills.

Figure 4.5 presents the findings regarding therapists' involvement in developing life skills.



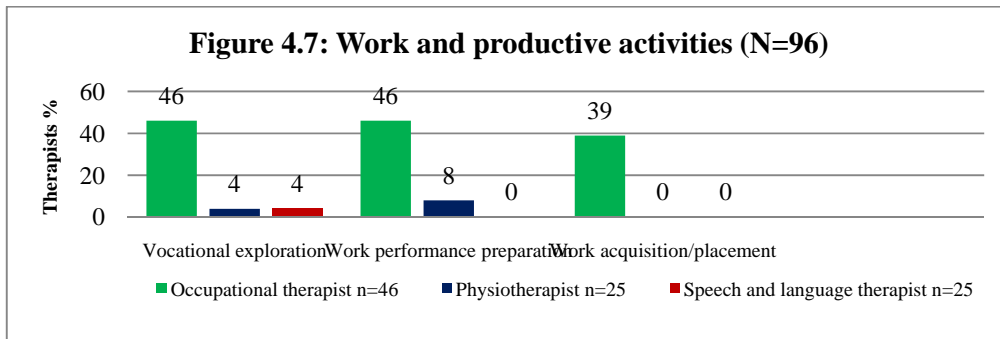
Occupational therapists contributed to all aspects of the development of social skills, while some physiotherapists were involved in developing community mobility skills. More speech and language therapists were involved in developing the socialisation aspect of life skills rather than other areas.

Figure 4.6 presents the findings on therapists' involvement in developing home management skills.



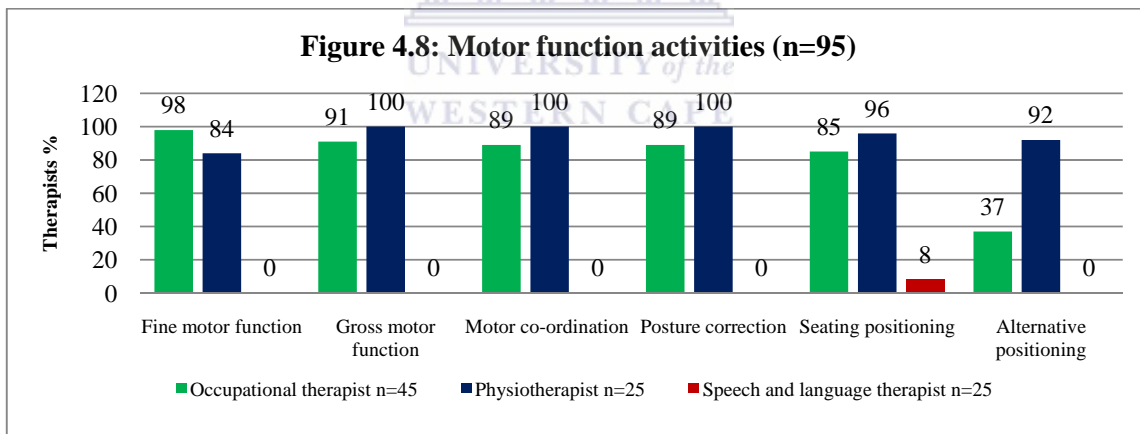
Occupational therapists were mostly involved in developing home management skills. This includes skills related to clothing care, cleaning the home, meal preparation/cleanup, shopping and money management skills. Very few physiotherapists, and no speech and language therapists, were involved in developing home management skills.

Figure 4.7 presents the findings on therapists' involvement in developing work and productive skills.



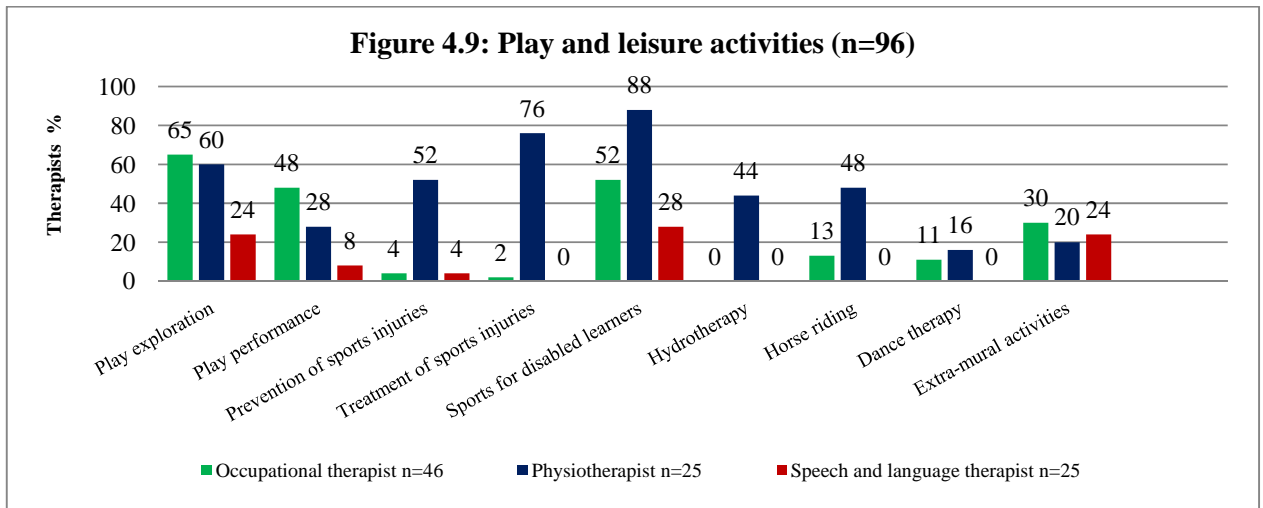
Many occupational therapists were involved in developing vocational exploration skills and work performance preparation and developing skills for work acquisition. Very few physiotherapists and speech and language therapists played a role in developing these activities.

Figure 4.8 presents the findings on therapists' involvement in developing motor function activities.



Most occupational therapists and physiotherapists were involved in developing the motor skills of learners. This included developing fine motor function, gross motor function, motor co-ordination, postural correction and seating positioning. Most physiotherapists provided alternative positioning for learners, for example lying or standing positioning.

Figure 4.9 presents the findings on therapists' involvement in developing play and leisure activities.



Most occupational therapists and physiotherapists indicated that they developed play exploration skills and sports for disabled learners. Most physiotherapists were involved in the prevention and the treatment of sports injuries.

Table 4.5 presents the therapists' involvement in counselling of learners.

Table 4.5 Counselling (n=88)

| | OT | PT | SLT |
|-----------------------------------|------|------|------|
| | n=45 | n=22 | n=21 |
| | % | % | % |
| Involvement in formal counselling | 18 | 14 | 5 |

OT= occupational therapy, PT= physiotherapy, SLT= speech and language therapy

A small percentage of therapists were involved in the formal counselling of learners.

4.2.1.3 Evaluation of intervention, management and treatment

Table 4.6 presents the percentage of therapists evaluating their direct support.

Table 4.6 Evaluation of direct support/treatment (n=96)

Figures in bold indicate 50% and more.

| Evaluation process | OT | PT | SLT |
|--|-----------|-----------|------------|
| | n=46 | n=25 | n=25 |
| | % | % | % |
| Always evaluated interventions | 76 | 84 | 76 |
| Sometimes evaluated interventions | 22 | 16 | 24 |
| Used “regular” assessment procedures | 65 | 56 | 76 |
| Evaluated if “goal was achieved within proposed timeframe” | 80 | 80 | 68 |

OT= Occupational therapist, PT= physiotherapist, SLT= speech and language therapist

The majority of therapists always evaluated their interventions and also evaluated whether the goal was achieved within the proposed timeframe. Most therapists used regular assessment procedures. A small group of therapists sometimes evaluated their interventions.

Table 4.7 presents the reasons therapists gave for not evaluating their treatment.

Table 4.7 Therapists’ reasons for sometimes and never evaluating their treatment (n=96). Figures in bold indicate 50% and more.

| Reason for not evaluating treatment | OT | PT | SLT |
|--|-----------|-----------|------------|
| | n=46 | n=25 | n=25 |
| | % | % | % |
| Measurable goals are not set with all learners | 9 | 16 | 12 |
| Some goals are difficult to evaluate | 13 | 12 | 8 |
| Insufficient time to evaluate | 20 | 12 | 12 |

OT= Occupational therapist, PT= physiotherapist, SLT= speech and language therapist

The minority of therapists were not evaluating their treatment interventions.

4.2.1.4 Multidisciplinary support teams

Table 4.8 indicates the proportion of therapists who were including professionals from other disciplines in identifying the learners' support needs, the treatment goals and in the evaluation of outcome of support.

Table 4.8 Therapists who made joint decisions with others (n=96)

Figures in bold indicate 50% and more.

| Decision made with: | Frequency | Identification of support needs and treatment goal | | | Evaluation: outcome of support | | |
|---------------------|-----------|--|-----------|-----------|--------------------------------|-----------|-----------|
| | | OT % | PT % | SLT % | OT % | PT % | SLT % |
| Learner | Always | 60 | 71 | 50 | 69 | 80 | 77 |
| | Sometimes | 41 | 25 | 42 | 25 | 20 | 22 |
| | Never | 0 | 4 | 8 | 5 | 0 | 0 |
| Parents | Always | 41 | 52 | 48 | 33 | 28 | 36 |
| | Sometimes | 57 | 48 | 44 | 64 | 64 | 55 |
| | Never | 2 | 0 | 8 | 3 | 8 | 9 |
| Educator | Always | 87 | 76 | 72 | 67 | 46 | 52 |
| | Sometimes | 13 | 24 | 28 | 33 | 54 | 48 |
| | Never | 0 | 0 | 0 | 0 | 0 | 0 |
| OT | Always | 56 | 64 | 44 | 53 | 30 | 25 |
| | Sometimes | 44 | 36 | 48 | 46 | 65 | 63 |
| | Never | 0 | 0 | 9 | 0 | 4 | 13 |
| PT | Always | 42 | 91 | 33 | 17 | 70 | 13 |
| | Sometimes | 53 | 9 | 48 | 72 | 20 | 67 |
| | never | 3 | 0 | 19 | 10 | 10 | 20 |
| SLT | Always | 44 | 41 | 60 | 28 | 11 | 33 |

| | | OT | PT | SLT | | OT | PT | SLT |
|---------------|-----------|-----------|-----------|-----------|--|-----------|-----------|-----------|
| | | % | % | % | | % | % | % |
| | Sometimes | 53 | 55 | 40 | | 68 | 72 | 60 |
| | never | 3 | 5 | 0 | | 9 | 17 | 7 |
| Psychologist | Always | 46 | 41 | 44 | | 28 | 13 | 24 |
| | Sometimes | 54 | 50 | 39 | | 62 | 75 | 57 |
| | never | 0 | 9 | 17 | | 10 | 13 | 19 |
| School nurse | Always | 19 | 52 | 17 | | 18 | 35 | 7 |
| | Sometimes | 75 | 39 | 50 | | 64 | 60 | 43 |
| | never | 6 | 9 | 33 | | 18 | 5 | 50 |
| Social worker | Always | 10 | 31 | 15 | | 0 | 10 | 0 |
| | Sometimes | 48 | 46 | 23 | | 0 | 10 | 0 |
| | Never | 0 | 0 | 0 | | 0 | 0 | 0 |

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

Most therapists *always* included the learner when evaluating support needs, the treatment goal and the outcome of their support.

Most physiotherapists *always* involved the parents, whereas most occupational therapists *sometimes* included the parents in identifying the learner's needs. Most therapists indicated involving the parents *only sometimes* when evaluating the outcome of support.

The majority of therapists *always* included the educator when identifying the learner's needs. The educator was *only sometimes* included by most of physiotherapists, but was *always* included by most of occupational therapists and speech and language therapists when evaluating the outcome of support.

Most occupational therapists and physiotherapists *always* included an occupational therapist with identifying learners' needs. Most occupational therapists *always* involved another occupational therapist when evaluating the intervention. Most physiotherapists and speech and language therapists *sometimes* involved an occupational therapist to evaluate the outcome of their support.

Most physiotherapists *always* included another physiotherapist but most of occupational therapists *sometimes* involved a physiotherapist when assessing support needs. When evaluating the outcome of support, most of physiotherapists *always* involved another physiotherapist but most of occupational therapists and speech and language therapists *sometimes* included a physiotherapist.

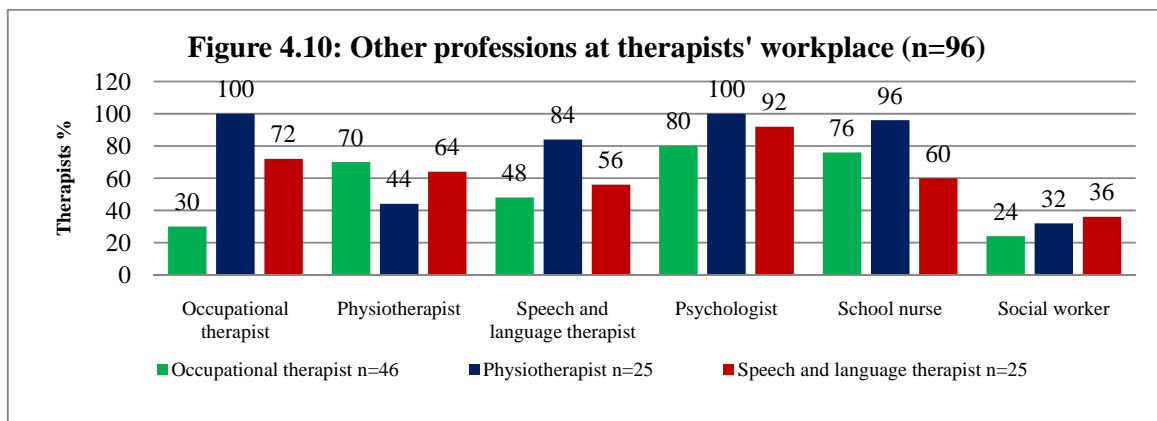
Most of speech and language therapists *always* included another speech and language therapist when assessing learners' needs, while most of occupational therapists and most of physiotherapists *sometimes* included a speech and language therapist. The majority of therapists *sometimes* involved a speech and language therapist when they evaluated the outcome of their support.

Most of occupational therapists and physiotherapists *sometimes* included a psychologist in the assessment of learners' needs. The majority of therapists *sometimes* included a psychologist when they evaluated the outcome of the intervention.

Most physiotherapists *always* included a school nurse in the assessment of learners' needs, while most occupational therapists and speech and language therapists *sometimes* involved the school nurse. Most of occupational therapists and physiotherapists *sometimes* included a school nurse when they evaluated the outcome of their support.

A small percentage of therapists included a social worker with the identification of support needs of learners and the evaluation of the outcome of support.

Figure 4.10 presents the percentage of therapists reporting the presence of other professions at their workplace.



Most therapists indicated that there were other professionals at their workplace. More occupational therapists indicated the presence of a physiotherapist, psychologist and a school nurse at their workplace. A few occupational therapists and physiotherapists had members of the same profession at their schools. The majority of physiotherapists had an occupational therapist, a speech and language therapist, a psychologist and a school nurse at their schools. More speech and language therapists had an occupational therapist, physiotherapist and another speech and language therapist at their schools. Most therapists had a psychologist and a school nurse at their workplaces. A few therapists reported the presence of a social worker at their workplaces.

4.2.1.5 Referral of learners to therapists outside the school.

Table 4.9 indicates the percentage of therapists referring learners to other therapists outside the school.

Table 4.9 Therapists referring to therapists outside school (n=93)

| | OT | PT | SLT |
|---|-----------|-----------|------------|
| | n=43 | n=25 | n=25 |
| | % | % | % |
| Referring learners to therapists outside the school for direct support | 63 | 56 | 60 |

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

Most therapists reported referring learners to other therapists outside school.

Table 4.10 presents the percentage of therapists referring to other therapists in state hospital and private hospital.

Table 4.10 Therapists referring to other therapists in state hospital and private practice (n=96).

| | OT | PT | SLT |
|----------------------------------|-----------|-----------|------------|
| | n=46 | n=25 | n=25 |
| | % | % | % |
| Refer to OT in state hospital | 26 | 20 | 20 |
| Refer to PT in state hospital | 24 | 36 | 16 |
| Refer to SLT in state hospital | 22 | 12 | 40 |
| Refer to OT in private practice | 33 | 16 | 24 |
| Refer to PT in private practice | 20 | 40 | 16 |
| Refer to SLT in private practice | 24 | 28 | 44 |

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

The findings indicate that therapists tended to refer learners to professionals from their own discipline in state hospitals and to private practices, but more therapists refer learners to their colleagues of the same profession in private practice than to those in the state sector.

Table 4.11 presents the findings indicating the reasons therapists do not refer learners to other therapists in the state hospitals and the private practices.

Table 4.11 Therapists' reasons for not referring learners to other therapists (n=96)

| | OT | PT | SLT |
|---|-----------|-----------|------------|
| | n=46 | n=25 | n=25 |
| | % | % | % |
| Learners get acceptable support from therapists in school | 20 | 40 | 20 |
| Families cannot afford costs | 26 | 36 | 20 |
| No private practitioners available | 2 | 0 | 0 |

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

Of the total number assessed, 40% of physiotherapists reported that learners get acceptable support from therapists at the school and that families cannot afford the costs of going

elsewhere for therapy. A very small percentage of occupational therapists reported that no private practitioners were available.

4.2.1.6 Summary

Findings presented in Sections 4.2.1.1 to 4.2.1.5 reflected the direct support that therapists provided to learners. It included the assessment of learners, the treatment or the intervention and the evaluation of these interventions.

4.2.2 Indirect learner support

This section presents the findings on therapists' indirect support to the learners via the educator, the parents and through making the environment and curriculum accessible. This includes support for non-teaching personnel, the provision of assistive devices, support for learners in ordinary schools, management responsibility, and support for the community and advocacy.

4.2.2.1 Support to educators

Table 4.12 presents the percentage of therapists giving support to the educators individually or in groups. It indicates the frequency of their support and whether support is given in groups or individually.

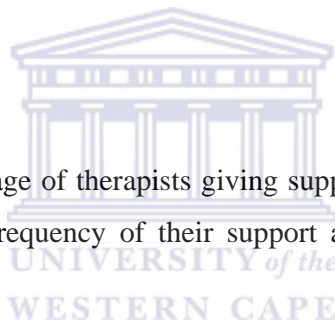


Table 4.12 Therapists giving support to educators (n=90). Figures in bold indicate 50% and more.

| | Frequency | OT | PT | SLT |
|---|-----------|-----------|-----------|-----------|
| Individual support to educators in special schools | Often | 74 | 84 | 50 |
| | Sometimes | 26 | 13 | 42 |
| Individual support to educators in ordinary schools | Often | 0 | 6 | 11 |
| | Sometimes | 75 | 44 | 53 |
| Individual support to Educator Support Teams at schools | Never | 25 | 50 | 37 |
| | Often | 10 | 13 | 10 |
| | Sometimes | 50 | 31 | 52 |
| Individual support to educators at EMDC/school clinic | Never | 40 | 56 | 38 |
| | Often | 4 | 0 | 10 |

| | Frequency | OT | PT | SLT |
|--|-----------|-----------|-----------|-----------|
| | Sometimes | 15 | 15 | 19 |
| | Never | 82 | 85 | 71 |
| Support in groups to educators in special schools | Often | 29 | 25 | 15 |
| | Sometimes | 69 | 75 | 65 |
| | Never | 3 | 0 | 20 |
| Support in groups to educators in ordinary schools | Often | 3 | 0 | 10 |
| | Sometimes | 73 | 59 | 50 |
| | Never | 23 | 41 | 40 |
| Support in groups to Educator Support Teams at schools | Often | 8 | 0 | 10 |
| | Sometimes | 59 | 42 | 48 |
| | Never | 37 | 58 | 43 |
| Support in groups to educators at the EMDC/school clinic | Often | 0 | 0 | 10 |
| | Sometimes | 27 | 39 | 14 |
| | Never | 73 | 62 | 76 |

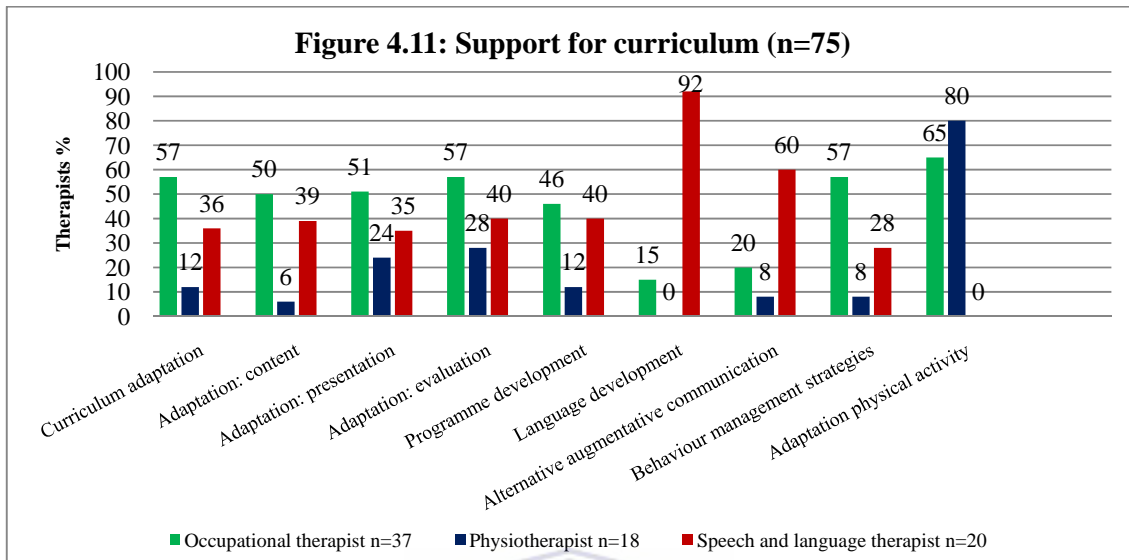
OT= occupational therapist, PT= physiotherapist, SLT= speech and language therapist.

The majority of occupational therapists *often* gave individual support and *sometimes* group support to educators in special schools, and they also *sometimes* gave individual and group support to educators in ordinary schools. The majority of occupational therapists *sometimes* gave individual and group support to educator support teams (TSTs) at schools, and they *never* gave individual or group support to educators at the EMDC/school clinic.

The majority of physiotherapists *often* gave individual support and *sometimes* group support to educators at special schools, and they *sometimes* gave group support but *never* individual support to educators in ordinary schools. The majority of physiotherapists *never* gave individual or group support to TSTs at schools, and they also *never* gave individual or group support to educators at the EMDC/school clinic.

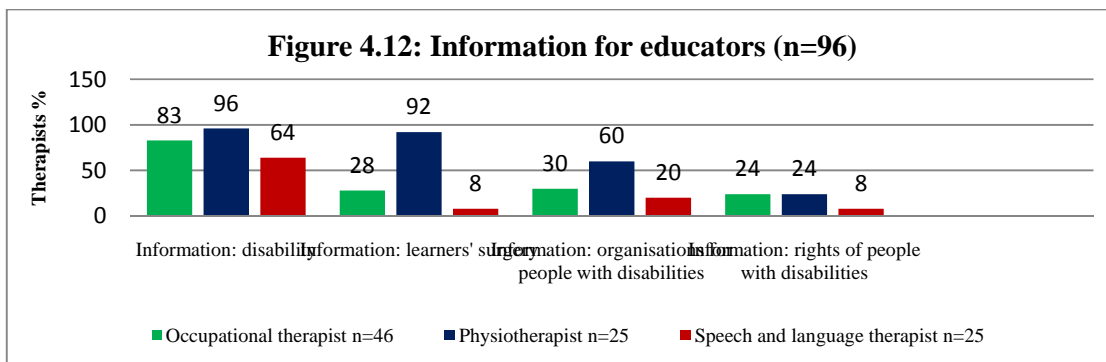
The majority of speech and language therapists *often* gave individual and *sometimes* group support to educators in special schools, and they also *sometimes* gave individual and group support to ordinary schools. The majority of speech and language therapists *sometimes* gave individual support to TSTs at schools, and they *never* gave individual or group support to educators at the EMDC/school clinic.

Figure 4.11 presents the findings on how therapists provided support to educators to make the curriculum more accessible to learners.



Most occupational therapists were involved in the adaptation of the curriculum by adapting the content, developing alternative ways presenting the curriculum, adapting the ways to evaluate the learners and assisting educators to adapt physical activities. The majority of physiotherapists were involved in assisting educators to adapt physical activity. Most speech and language therapists were involved in supporting educators in language development and alternative augmentative communication.

Findings on information provided to educators are presented in Figure 4.12.



Most therapists provided educators with information about learners' disabilities. Most physiotherapists provided information about the learners' surgery and organisations for people with disabilities. A small percentage of therapists provided information about the rights of people with disabilities.

4.2.2.2. Support to non-teaching school personnel

Therapists provided support to educators as well as non-teaching personnel, who included classroom assistants, hostel personnel, bus drivers and administrative personnel. Table 4.13 presents the percentage of therapists providing training to non-teaching staff.

Table 4.13 Therapists providing training to non-teaching staff (n=90). Figures in bold indicate 50% and more.

| | OT n=42 % | PT n=25 % | SLT n=23 % |
|--------------------------|------------------------|------------------------|-------------------------|
| Classroom assistants | 79 | 92 | 74 |
| Hostel personnel | 43 | 58 | 33 |
| Bus drivers | 45 | 96 | 11 |
| Administrative personnel | 21 | 53 | 17 |

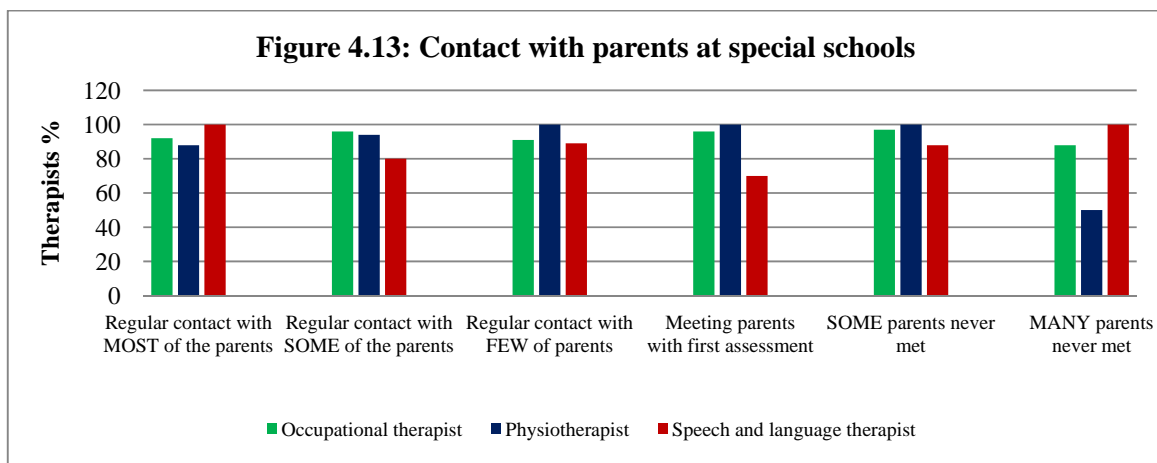
OT= occupational therapist, PT= physiotherapist, SLT= speech and language therapist

Most therapists provided training to classroom assistants. Most physiotherapists were involved in the training of hostel personnel, bus drivers and administrative personnel.

4.2.2.3 Support to parents

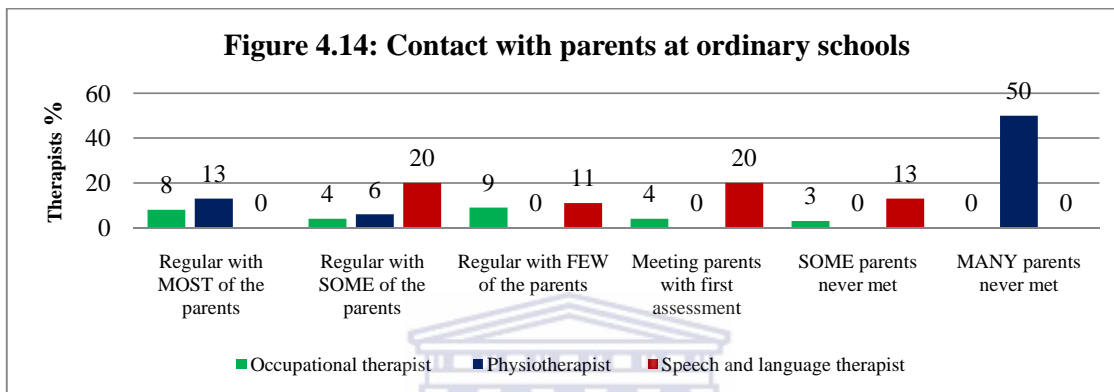
Support for parents involves the development of parents' knowledge and skill, support provided in their homes, and advocacy and emotional support.

Figure 4:13 presents the findings of therapists' contact with parents at the special schools.



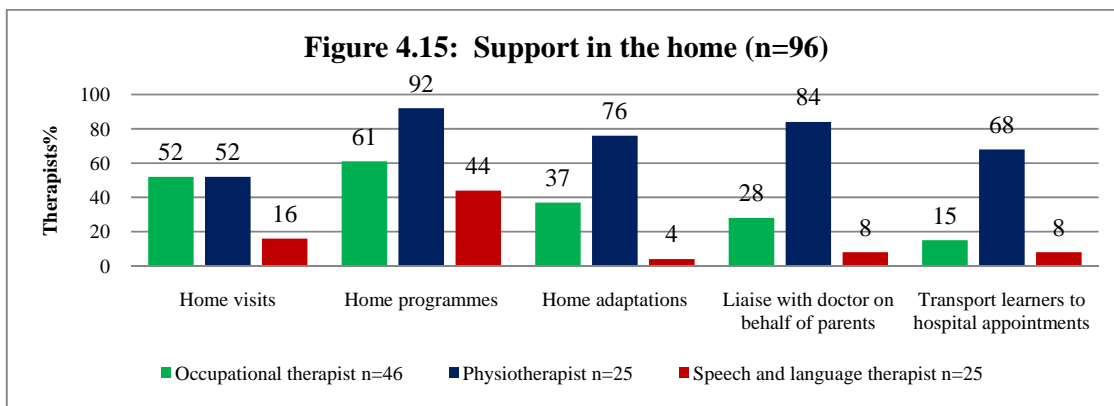
These results indicated that most therapists have regular contact with *most*, with *some* and also with *few* of the parents and, at the same time, indicated that they have *never met* many parents. These results are contradictory and suggest that the questions were incorrectly answered as these results cannot be satisfactorily interpreted.

Figure 4.14 presents the findings of the therapists' contact with parents at ordinary schools.



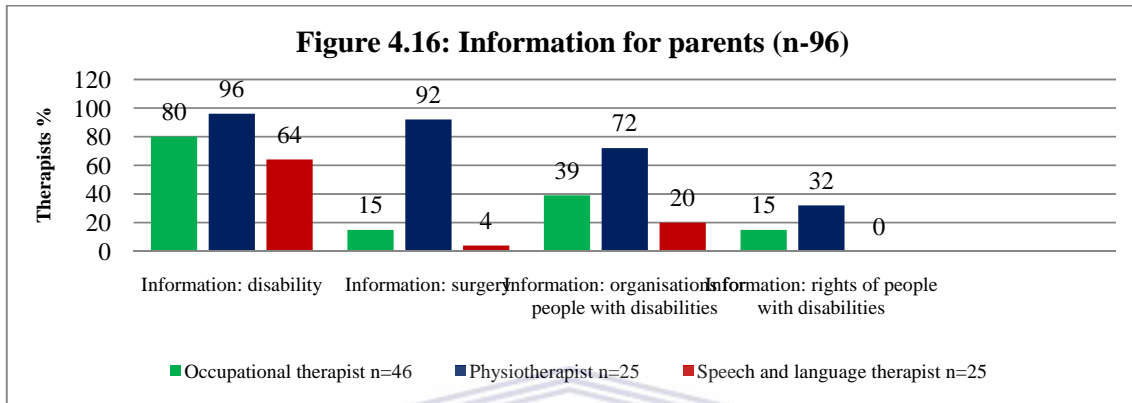
Most therapists indicated that they have never met many of the parents at ordinary school. Comparing results presented in Figures 4.13 and 4.14, the conclusion must be drawn that most therapists have met more parents in the special schools than in the ordinary schools because few therapists are working at the ordinary schools.

Figure 4.15 presents the findings of the support the therapists provided in the homes of learners.



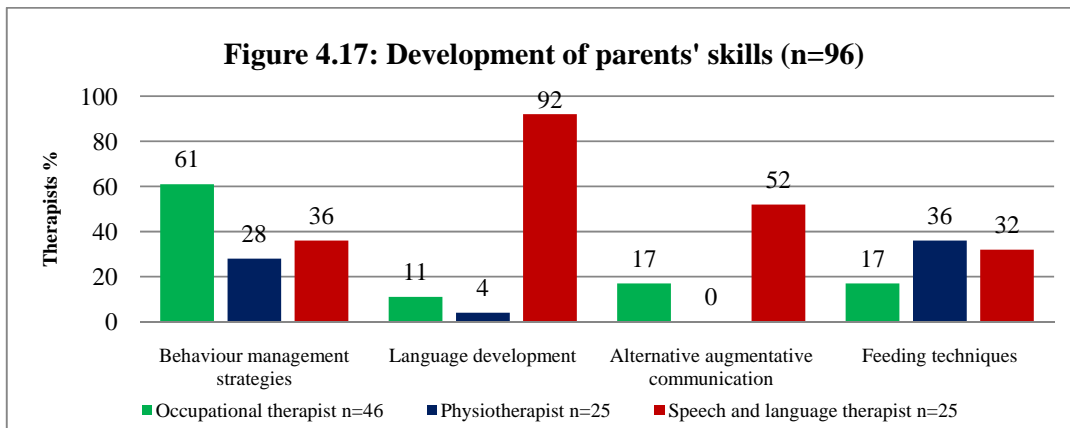
Most occupational therapists and physiotherapists were doing home visits and giving home programmes to parents. Most physiotherapists did home adaptations, liaised with the doctor on behalf of parents and transported learners to hospital appointments. A minority of speech and language therapists provided home programmes and provided support in the home.

Figure 4.16 presents the information the therapists provided to the parents.



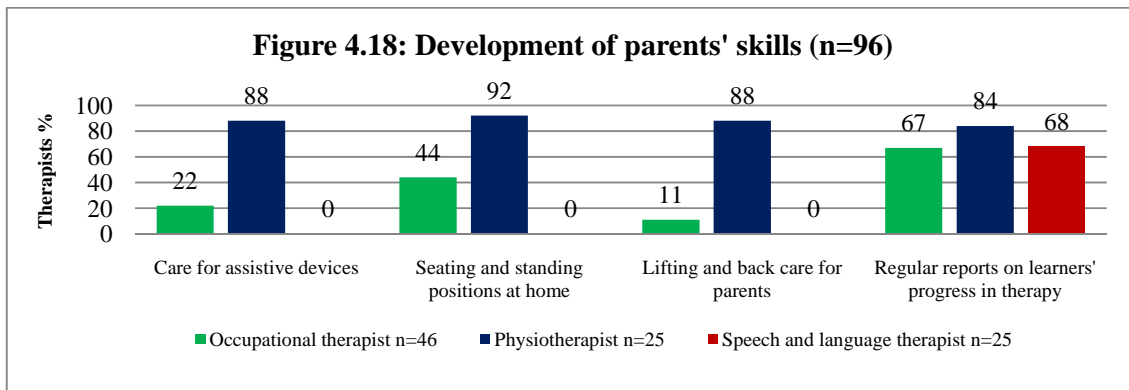
Most therapists were providing information on disability to parents. Most physiotherapists were providing information on learners' surgery and providing information about organisations for people with disability.

Figure 4.17 presents the findings on how the therapists developed the skills of parents.



Most occupational therapists were involved in teaching parents behaviour management strategies. The majority of speech and language therapists taught parents about language development and alternative augmentative communication.

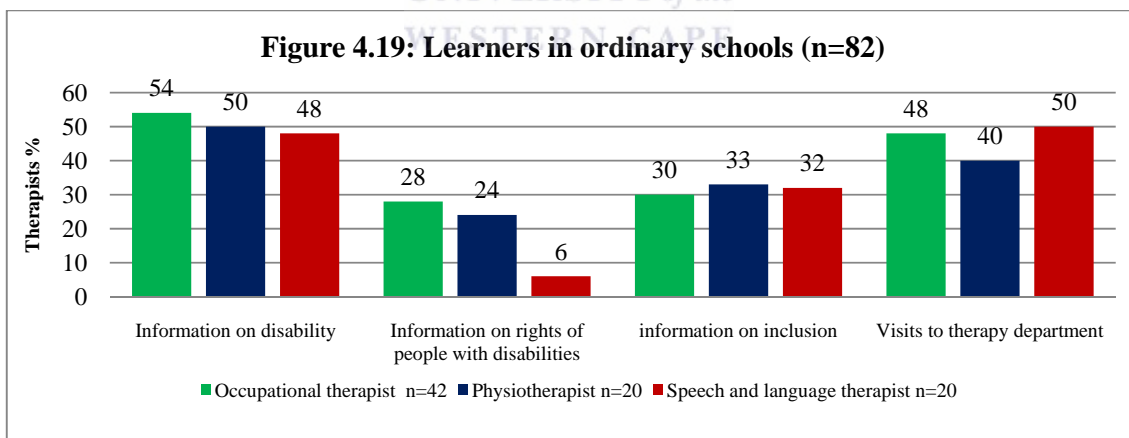
Figure 4.18 presents more findings on the development of parents' skills.



Most therapists were providing parents with regular reports on learners' progress in therapy. Most physiotherapists were playing a role in teaching parents how to care for assistive devices, recommending seating and standing positions at home, and advising parents on lifting and back care.

4.2.2.4 Support to learners in ordinary schools

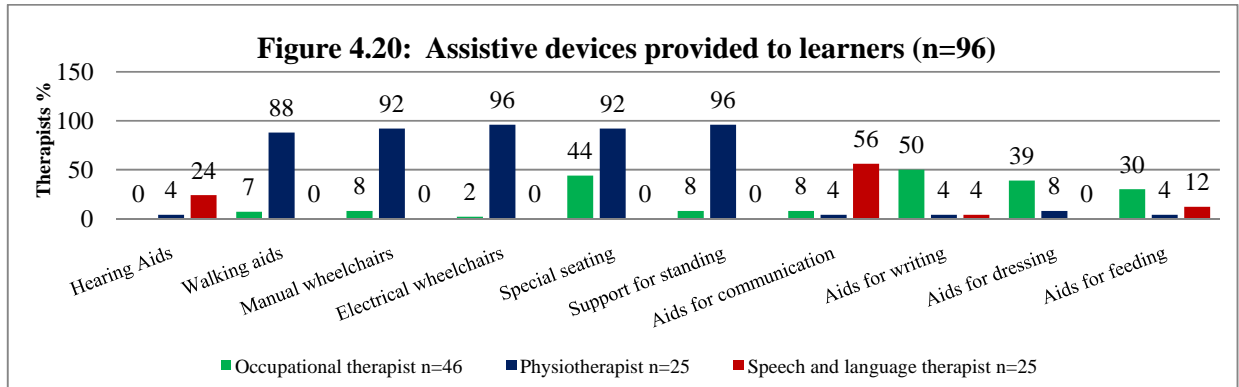
Figure 4.19 presents the results of the support the therapists provided to learners in ordinary schools.



Most therapists were involved in providing information on disability to learners from ordinary schools. Most therapists were involved with the visits of learners from ordinary schools to the therapy department at a special school. A few therapists played a minor role in providing information about inclusion to learners in ordinary schools.

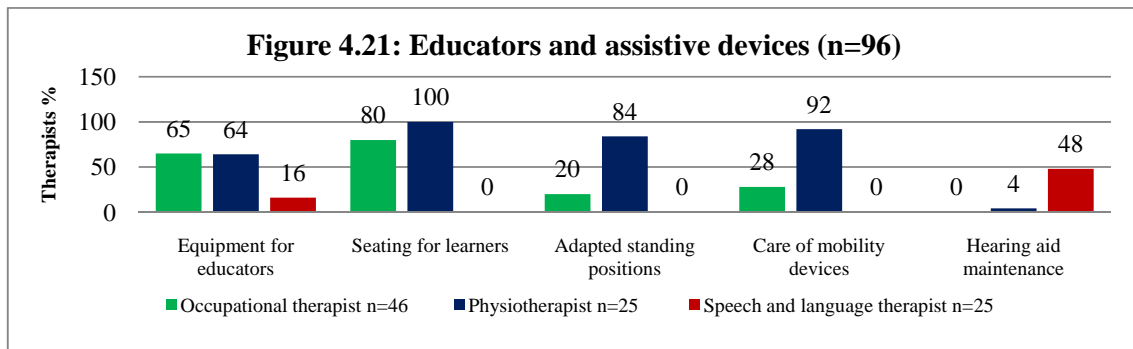
4.2.2.5 Provision of assistive devices

Figure 4.20 presents the findings related to the therapists providing assistive devices to learners.



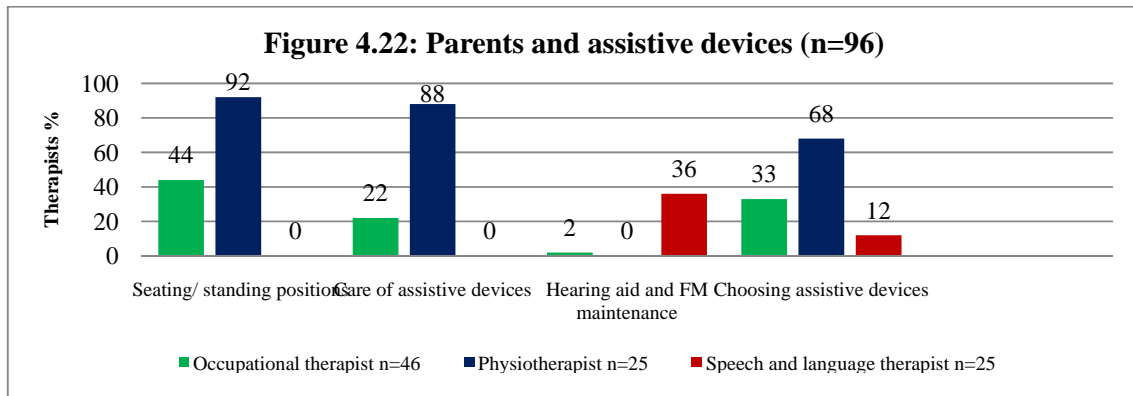
Most occupational therapists were involved in providing aids for writing. Most physiotherapists indicated that they provided walking aids, manual and electrical wheelchairs, special seating and support for standing. Most speech and language therapists provided aids for communication.

Figure 4.21 presents the findings on the therapists' support to educators related to assistive devices.



Most occupational therapists and physiotherapists were providing equipment to educators and taught them about special seating for learners. Most physiotherapists trained the educators how to put learners in adapted standing positions and how to take care of mobility devices.

Figure 4.22 presents the findings on the therapists' support to parents, related to assistive devices.



Most physiotherapists were involved in teaching parents about seating and standing positions and how to take care of assistive devices, and in involving parents in choosing an assistive device except for hearing aid and FM maintenance.

Table 4.14 presents the findings on the therapists' roles in making assistive devices.

Table 4.14 Therapists' roles in making assistive devices (n=96). Figures in bold indicate 50% and more.

| Assistive device | OT n=46 % | PT n=25 % | SLT n=25 % |
|--------------------------|-----------------|-----------------|------------------|
| Ear moulds | 0 | 0 | 12 |
| Arm splints | 8 | 4 | 0 |
| Leg/foot splints | 0 | 28 | 0 |
| Special seating | 24 | 72 | 0 |
| Special standing support | 4 | 32 | 0 |

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

Most physiotherapists were involved with making special seating for learners with disabilities.

Table 4.15 presents the findings of therapists' roles in maintaining and repairing assistive devices.

Table 4.15 Therapists' roles in maintenance and repair of assistive devices (n=96).

Figures in bold indicate 50% and more.

| | OT n=46 % | PT n=25 % | SLT n=25 % |
|---|-----------------|-----------------|------------------|
| Maintain assistive devices | 37 | 76 | 36 |
| Repair assistive devices | 17 | 56 | 12 |
| Teaching learners to do some maintenance and repair | 8 | 48 | 12 |
| Involving parents in maintenance and repair | 7 | 48 | 12 |
| Organise for repairs to be done by someone else | 39 | 100 | 36 |
| No roles in maintenance and repair | 15 | 0 | 28 |

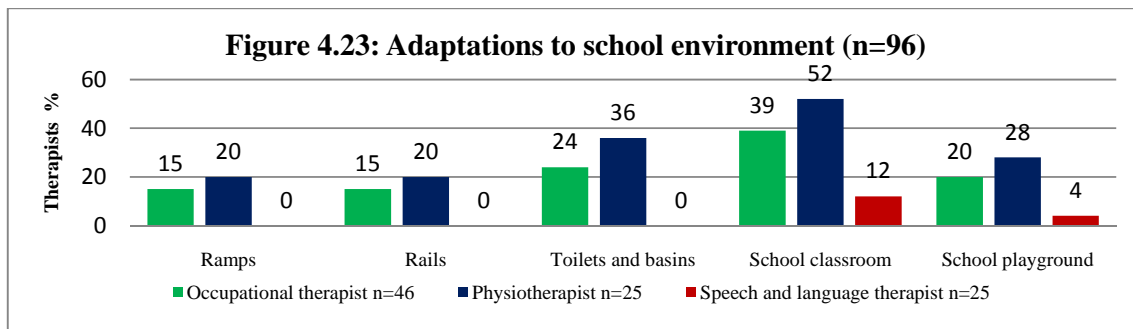
OT= occupational therapist, PT= physiotherapist, SLT= speech and language therapist

Most physiotherapists reported maintaining and repairing assistive devices as well as organising for repairs to be done by someone else.

4.2.2.6 Support to school physical and cultural environment

This section presents the results on the roles therapists played in developing the school physical and cultural environment to enable learners to access the curriculum, thus facilitating learning and development.

Figure 4.23 illustrates the support the therapists provided in adapting the school environment.



Most physiotherapists played a role in adapting the school classroom. Few occupational therapists and physiotherapists were involved in the other aspects of adapting the school

environment, for example, adapting toilets and basins, advising about ramps and rails, as well as adapting the school playground. Few speech and language therapists played a role in adapting the school classroom.

The therapists' involvement in developing a supportive school environment entails different aspects of school management. The therapists have been involved in administrative tasks, policy making, participating in team meetings and organising fundraising.

Table 4.16 presents the findings of therapists' management responsibilities.

Table 4.16 Therapists' management responsibilities (n=96)

Figures in bold indicate 50% and more.

| | OT | PT | SLT |
|--------------------------------|-----------|------------|-----------|
| | n=46 | n=25 | n=25 |
| | % | % | % |
| Administration | 94 | 80 | 88 |
| Influencing policy | 44 | 44 | 44 |
| Meetings: educators | 96 | 100 | 96 |
| Meetings: therapists | 87 | 100 | 92 |
| Meetings: EMDC | 35 | 28 | 32 |
| Meetings: NGOs | 22 | 36 | 12 |
| Member: SGB | 4 | 12 | 4 |
| Member: school committee | 39 | 36 | 44 |
| Fundraising: special school | 72 | 72 | 72 |
| Fundraising: assistive devices | 13 | 60 | 20 |

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

Most of the therapists were involved with administrative duties, including meetings with educators and other therapists, as well as doing fundraising for the special school. Only a small percentage of therapists indicated being members of school governing bodies. Most of the physiotherapists were involved in fundraising activities for assistive devices.

4.2.2.7 Support to the community

Table 4.16 presents the results on therapists' involvement in developing the therapy department as a resource centre.

Table 4.17 Therapists involved in developing department as resource centre (n=79)

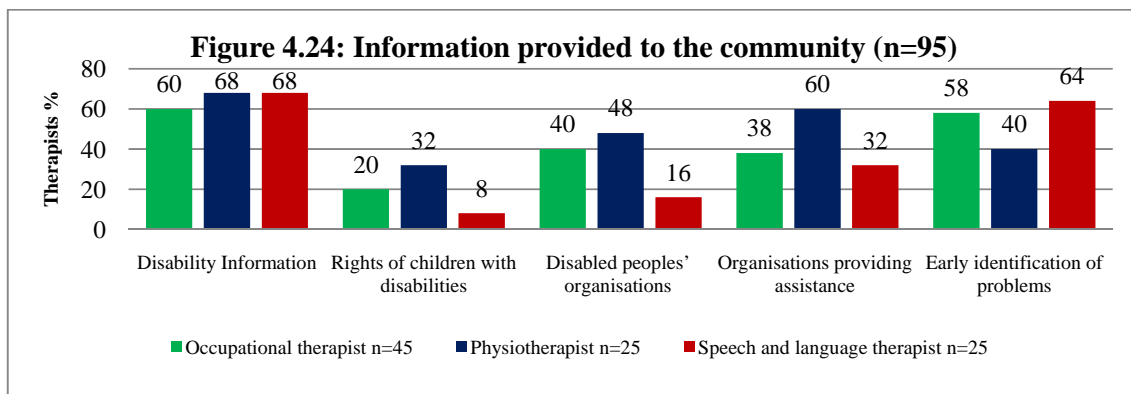
| | OT n=38 % | PT n=19 % | SLT n=22 % |
|--|-----------------|-----------------|------------------|
| Developing therapy department as a resource centre | 84 | 74 | 77 |

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

The majority of therapists indicated that they were developing their departments as resource centres.

Therapists supported the community by providing information in general and about organisations for people with disabilities. Training was also done in the form of open days, workshops and talks in the community.

Figure 4.24 presents the findings on the information that the therapists provided to the community.



Most therapists provided the community with information about disability. Most physiotherapists provided information on organisations that provide assistance for children with disabilities. Most occupational therapists and speech and language therapists provided information regarding early identification of problems.

Table 4.18 presents the findings on the training the therapists provided to the community.

Table 4.18 Therapists providing training to community (n=95)

| | OT | PT | SLT |
|--------------------------------|-----------|-----------|------------|
| Training for | n=45 | n=25 | n=25 |
| | % | % | % |
| Community based workers | 7 | 8 | 16 |
| Volunteers to assist in school | 16 | 28 | 24 |

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

Table 4.19 presents the findings of the different approaches the therapists used when providing training to the community.

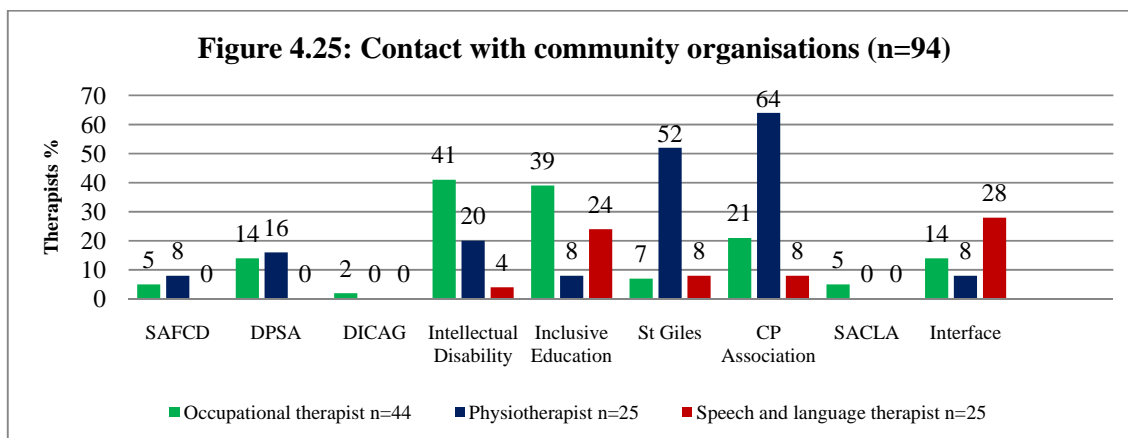
Table 4.19 Training approach used in the community (n=95)

| | OT | PT | SLT |
|---|-----------|-----------|------------|
| | n=45 | n=25 | n=25 |
| | % | % | % |
| Open days at special school for the community | 42 | 28 | 44 |
| Talks in the community | 20 | 24 | 20 |
| Workshops in the community | 7 | 4 | 16 |

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

The majority of therapists were not involved in these aspects of training in the community.

Figure 4.25 presents the findings on the contact therapists had had with community organisations and organisations for people with disabilities over the previous year.



Most physiotherapists made contact with St Giles and the Cerebral Palsy Association. Some occupational therapists had made contact with the Western Cape Forum for Intellectual Disability and the Western Cape Forum for Inclusive Education. The minority of speech and language therapists had contacted Interface.

4.2.2.8 Advocacy

Therapists' involvement in advocacy with parents, educators and local campaigns to involve the community in inclusive education is shown in Table 4.20.

Table 4.20 Therapists' involvement with advocacy (n=96)

| | OT | PT | SLT |
|---|------|------|------|
| | n=46 | n=25 | n=25 |
| | % | % | % |
| With parents to accept children in ordinary school | 30 | 24 | 16 |
| With educators to accept learners from special school | 35 | 24 | 12 |
| Participation in local campaign(s) | 11 | 4 | 12 |

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

The majority of therapists were not involved in advocacy.

4.2.2.9 Overlapping roles of therapists

The results indicated that therapists played their traditional roles but at times overlapping of roles occurred. Table 4.21 presents the overlapping roles of therapists.

Table 4.21: Roles of therapists (as indicated by at least 30 % of the sample)

| Occupational therapy – physiotherapy – speech & language therapy | |
|---|--|
| <p>Life/ social skills Socialisation</p> <p>Play and leisure activities Sports for disabled learners</p> <p>Support for educators Information disability</p> <p>Support for learners in ordinary school Information: disability Information: inclusion Visits to therapy department</p> | <p>Support for parents Home programmes Information: disability Regular reports on learners' progress</p> <p>Community support Information on disability Information: organisations providing assistance Information: early identification of problems</p> <p>Support to non-teaching personnel Training of classroom and hostel personnel</p> |

| Occupational therapy - Physiotherapy | |
|---|--|
| <p>Activities of daily living Toilet hygiene Dressing Feeding and eating</p> <p>Motor function activities Fine motor function Gross motor function Motor coordination Posture correction Seating positioning Alternative positioning</p> <p>Play and leisure activities Play exploration Sports for disabled learners</p> <p>Support for educators Curriculum support: adaptation physical activity Information: organisations for people with disability</p> | <p>Support for parents Home adaptations Home visits Information: organisations for people with disability Seating and standing positions at home Advice parents choosing assistive devices</p> <p>Assistive devices (provision, maintenance, repair) Special seating aids Equipment for educators</p> <p>Environmental support Adaptation: school classroom</p> <p>Community support Information: disabled peoples' organisation</p> <p>Support to non-teaching personnel Training of bus drivers</p> |
| <p><u>Occupational therapy-Speech & language therapy</u></p> <p>Support for educators Curriculum adaptation Adaptation content, presentation and evaluation Programme development</p> <p>Support for parent Skills: behaviour management strategies</p> | <p><u>Physiotherapy-Speech & Language therapy</u></p> <p>Support for parents Skills: feeding techniques</p> |

Table 4.21: Roles of therapists (as indicated by at least 30 % of the sample) continued

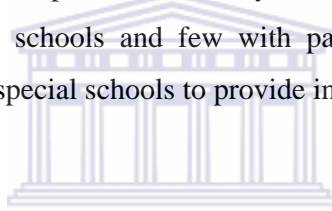
| | | |
|---|---|---|
| <p><u>Occupational therapy</u></p> <p>Activities of daily living</p> <p>Oral hygiene</p> <p>Grooming</p> <p>Hearing/speech/communication skills</p> <p>Visual perception skills</p> <p>Life skills and social skills</p> <p>Health maintenance</p> <p>Work and productive activities</p> <p>Vocational exploration</p> <p>Work performance</p> <p>Work acquisition/placement</p> <p>Assistive devices (provision, maintenance, repair)</p> <p>Aids for writing</p> <p>Aids for dressing</p> <p>Aids for feeding</p> <p>Advocacy</p> <p>With parents to accept children in ordinary schools</p> <p>With educators to accept learners from special schools</p> <p>Play and leisure activities</p> <p>Play performance</p> <p>Extramural activities</p> <p>Support for educators</p> <p>Curriculum support: behaviour management strategies</p> | <p><u>Physiotherapy</u></p> <p>Activities of daily living</p> <p>Personal device care</p> <p>Life skills & social skills</p> <p>community mobility</p> <p>Play & leisure activities</p> <p>Prevention of sports injuries</p> <p>Treatment of sports injuries</p> <p>Hydrotherapy</p> <p>Horse riding</p> <p>Assistive devices (provision, maintenance, repair)</p> <p>Walking aids</p> <p>Manual wheelchairs</p> <p>Electrical wheelchairs</p> <p>Standing aids</p> <p>Special seating aids</p> <p>Support for educators</p> <p>Information: surgery</p> <p>Adapted standing positions</p> <p>Care of mobility devices</p> <p>Support for parents</p> <p>Liase with doctor on behalf of parents</p> <p>Transport learners to hospital appointments</p> <p>Information: surgery</p> <p>Information: rights of people with disability</p> <p>Care for assistive device</p> <p>Skills: lifting techniques and back care</p> <p>Environmental support</p> <p>Adaptations: toilets and basins</p> <p>Support for the community</p> <p>Information: rights of children with disabilities</p> <p>Support for non-teaching school personnel</p> <p>Training of Administrative personnel</p> | <p><u>Speech & language therapy</u></p> <p>Hearing/speech/communication skills</p> <p>Hearing tests</p> <p>Language and speech skills</p> <p>Sign language</p> <p>Auditory perception</p> <p>Oral motor exercises</p> <p>Alternative augmentative communication</p> <p>Reading and spelling remediation</p> <p>Functional communication</p> <p>Assistive devices (provision, maintenance, repair)</p> <p>Aids for communication</p> <p>Support for parents</p> <p>Skills: language development</p> <p>Alternative augmentative communication</p> <p>Hearing aid and FM maintenance</p> <p>Support for educators</p> <p>Hearing aid maintenance</p> <p>Language development</p> <p>Alternative augmentative communication</p> |
|---|---|---|

The results indicated that overlapping of roles occurred but therapists also had their own roles. Occupational therapists' unique roles were in work and productive activities, physiotherapists were providing assistive devices for mobility, and speech and language therapists were developing speech, hearing and communication skills.

4.2.2.10 Summary

This section presented the results of indirect support provided by therapists to the schooling community (Sections 4.2.2.1–4.2.2.9). More therapists provided support to educators in special schools than to the educators in ordinary schools. Most occupational therapists and speech and language therapists were involved in adapting the curriculum. The majority of physiotherapists and occupational therapists supported educators with adapting physical activity, while most speech and language therapists supported educators in language development. Most occupational therapists supported educators in strategies for behaviour management.

Most occupational therapists and physiotherapists were involved in adapting the school environment. Most physiotherapists provided mobility assistive devices. Most therapists had contact with parents in special schools and few with parents in ordinary schools. Most therapists used open days at the special schools to provide information to the community.



4.2.3 Proportion of time allocated for direct and indirect support

WESTERN CAPE

Therapists were asked to indicate what percentage of time they usually spent on direct and indirect support. They had to consider if they wanted to change the time spent on these different categories. The answers showed that 44% of occupational therapists, 52% of physiotherapists and 56% of speech and language therapists wanted to change the proportion of their time spent on direct versus indirect support in future. Furthermore, 44% of occupational therapists, 48% of occupational therapists and 28% of speech and language therapists indicated they did not want to change the proportion of their time spent on direct and indirect support. Table 4.22 provides the findings on how they currently spend their time and their desire to allocate their time for direct and indirect support in the future.

Table 4.22 Percentage of time the therapists spend on direct and indirect support (n=95)

| | OT | PT | SLT | OT | PT | SLT |
|---|---------|----|-----|--------|----|-----|
| | Present | | | Future | | |
| Direct support service for the learner | 60 | 60 | 67 | 78 | 76 | 71 |
| Indirect support service | | | | | | |
| • with the educators | 14 | 15 | 14 | 65 | 57 | 50 |
| • with the parents | 8 | 7 | 7 | 63 | 56 | 47 |
| • with general learners in ordinary schools | 3 | 2 | 2 | 62 | 51 | 40 |
| • changing the environment | 4 | 6 | 0 | 60 | 53 | 40 |
| • supporting the curriculum | 17 | 6 | 10 | 62 | 53 | 43 |
| • in the community | 14 | 3 | 7 | 61 | 54 | 43 |

These figures suggest that, currently, the majority of time is spent on direct support and the minority of time is currently spent on indirect support. The findings suggest that therapists want to increase the proportion of indirect support but also want to increase direct support. It is possible that therapists did not understand this question, because the total calculation of direct and different categories of indirect support should have added up to a total of 100% but it did not.

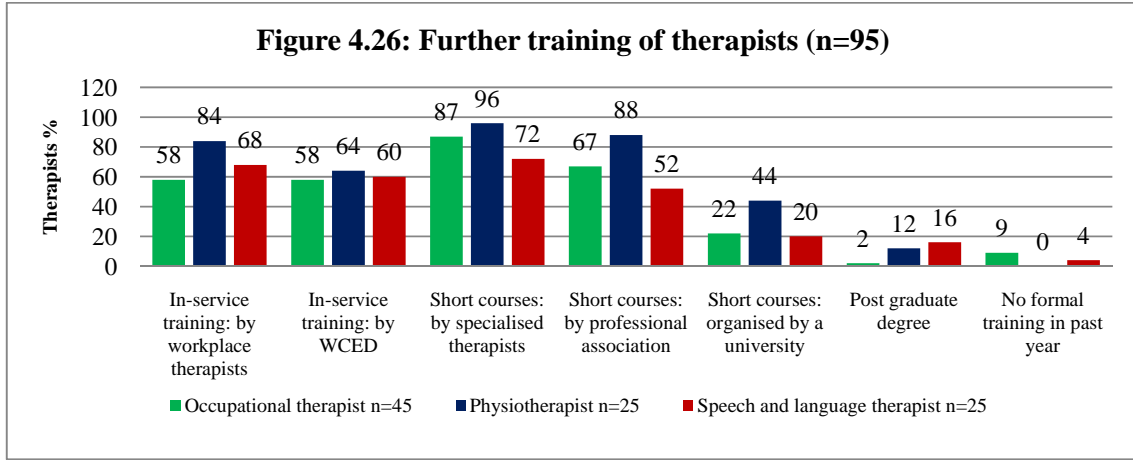
4.2.4. Capacity development

Therapists developed their own capacity as well as that of others, for example, by supervising students.

4.2.4.1 Capacity development of therapists

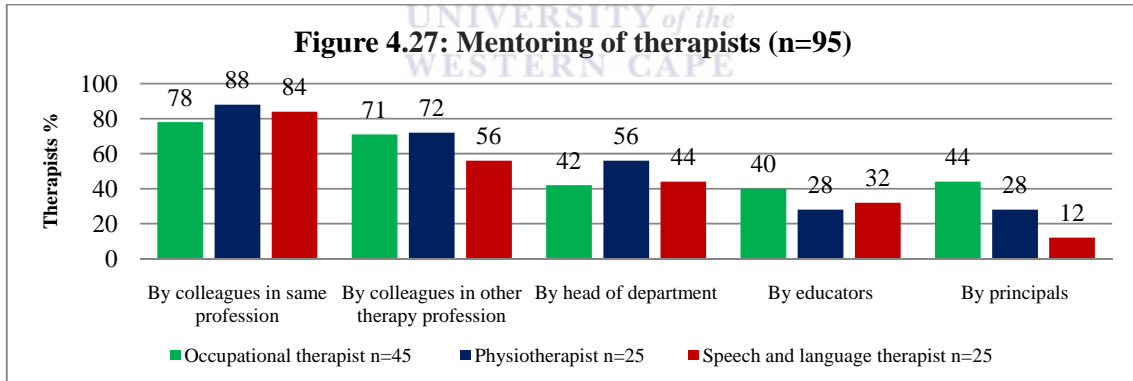
In this section, the results of therapists’ capacity development is presented, firstly, through training and, secondly, through support and mentoring given to them.

Figure 4.26 illustrates the capacity development of therapists by further training.



Most therapists gained their training through short courses provided by specialised therapists and their professional associations and in-service training provided by workplace therapists and the Western Cape Education Department.

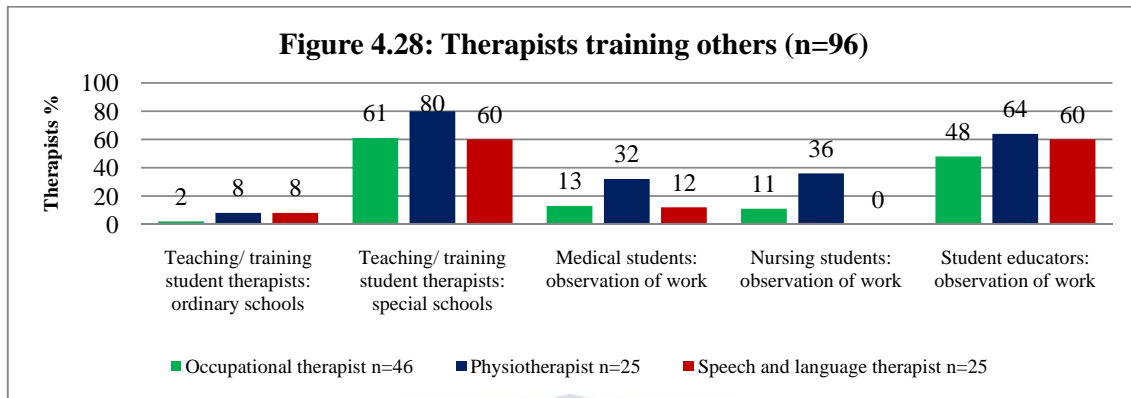
Figure 4.27 presents the capacity development of therapists through mentoring given to them.



Most therapists received mentoring from colleagues in the same profession or from colleagues in other therapy professions. Most physiotherapists received mentoring from the head of department.

4.2.4.2 Capacity development of others by therapists

Therapists were also involved in the development of the capacity of student therapists, medical and nursing students, and student educators. This is presented in Figure 4.28.



Most therapists were involved in training student therapists in the special schools. Most physiotherapists and speech and language therapists were involved in the training of student educators.

4.2.4.3 Summary

Most therapists obtained their ongoing training through short courses provided by specialised therapists and their professional associations and in-service training provided by workplace therapists and the Western Cape Education Department. Most therapists received mentoring from colleagues in the same profession or from colleagues in other therapy professions. Most therapists were involved with training student therapists in special schools.

4.2.5 Conclusion

Section A presented the findings regarding direct support and indirect support provided by the therapists and the capacity development of therapists.

The next section presents the results of the analysis of the qualitative data, namely the group interviews.

4.3 SECTION B: RESULTS OF GROUP INTERVIEWS

In this section, the results of the three group interviews are presented. These are related to Objectives 2 and 3. Objective 2 was to determine the barriers that prevent therapists from providing their support in an inclusive education. Objective 3 was to determine the facilitators that support therapists when they provide their support in an inclusive education system.

4.4 BACKGROUND

The three group interviews were all held at three different special schools in three different EMDCs, namely, EMDC North, EMDC South and Central EMDC. The participants of each group were employed and based at the particular special school.

The first group interview was held at Special School Yellow. The special school, ordinary school and the principal at the special school attached to this group will be referred to by the colour yellow in the text, for example, Special School Yellow, Ordinary School Yellow and Principal Yellow. This group consisted of five therapists who indicated that they had minimum exposure working in the community and were not involved in community projects at the time of the study. One or two of these therapists could recall their support provision to ordinary schools, when learners from their special school were accepted at the ordinary schools. These therapists explained that, at that time, they were guided by the EMDC through workshops on inclusive education and support provision but could not continue this support when key roles players at the EMDC vacated their positions. The result was that therapists expressed confusion as to what their roles in the provision of support entailed.

In the second group interview at Special School Blue, the three participants had relatively good experience of attempting to implement community projects. The principal, special, ordinary school and full service school attached to this group will be referred to by the colour blue in the text, for example, the Principal Blue, the Special School Blue and the Ordinary School Blue. The therapists had tried to be involved in support provision to other schools. They said that these projects were stopped at various levels and no reason was given by the principal. The therapists indicated that red tape might have caused different authorities to stop their attempts, for example, the principal at Special School Blue and the managers at the EMDC. This group reported doing a small research project to establish the needs of educators and holding several workshops with educators at ordinary schools in collaboration with the

EMDC. The last workshop initiated by one of the therapists was successful, but when she arranged a follow-up workshop, it was stopped by Principal Blue at the special school. In the discussion, these therapists often referred to those times when they were allowed to provide their support to other schools. At the time of this study, the therapists had no community projects. This group, which consisted mainly of occupational therapists, was very enthusiastic and passionate about their work and suggested that they had more to offer than what the principal was allowing them to do. Because these therapists experienced satisfaction when they did provide their support to other schools, they expressed a great deal of frustration and powerlessness when not allowed to go out to the community.

The principal at the ordinary school, the principal at the full service school, the special school, the ordinary school, and the full service school attached to the third group discussion will be referred to by the colour red in the text, for example, the Principal Red, the Special School Red and the Ordinary School Red. The four participants in the third group were keen to work in ordinary schools. The therapists had approached the EMDC for advice regarding provision of support to an ordinary school but had received no response. This delayed response of the EMDC had been regarded as a barrier. However, the enthusiastic therapists went ahead anyway and made links to a farm school and provided their support with success for more than a year.

A year after starting the project, the therapists of the third group were asked to support a full service school. Although the therapists had worked in an ordinary school for more than a year, they still did not feel prepared to give support to the full service school. The therapists felt that the different role players at the full service school were not properly informed about what the therapists' support provision to their school involved. This developed into educators having different expectations from those which the therapists could meet and led to conflict between therapists and educators. Subsequently, the therapists decided to work with educators who were willing to co-operate, hoping to eventually convince other, unwilling educators to accept their support. The therapists currently have two projects, the first at the ordinary school, which is a farm school, and the second at a full service school.

4.4.1 Demography

The therapists who participated in the three group interviews had working experience that ranged from 3 to 35 years. All therapists were bilingual and the discussions took place in English. Table 4.22 presents the demographic data of participants.

Table 4.23 Demography of participants in group interviews

| | Therapist | Qualification | Gender | Age Years | Experience Years | Time at school Years |
|----------------------------|-----------|---------------|--------|--------------|---------------------|-------------------------------|
| Group 1 (Yellow School) | A | OT | Female | 31 | 6 | 0.5 |
| | B | OT | Female | 25 | 3 | 1 |
| | C | SLT | Female | 54 | 32 | 0.3 |
| | D | PT | Female | 43 | 19 | 6 |
| | E | PT | Female | 30 | 7.5 | 2.5 |
| Group 2 (Blue School) | K | OT | Female | 57 | 35 | 17.5 |
| | L | OT | Female | 44 | 18 | 18 |
| | M | OT | Female | 40 | 17.5 | 17.5 |
| Group3 (Red School) | S | OT | Female | 45 | 23 | 14.5 |
| | T | SLT | Female | 26 | 4 | 2.5 |
| | U | OT | Female | 30 | 8 | 1.5 |
| | V | PT | Female | 46 | 25 | 2.5 |

OT= Occupational therapist, PT=Physiotherapist, SLT = Speech and Language therapist

4.5 Themes

The barriers that prevent therapists from providing support provision to ordinary and full service schools and the facilitators that promote therapists' support provision to ordinary and full service schools are presented in the following themes that emerged from the data. Table 4.23 presents the themes obtained from the data.

Table 4.24 Themes

| CODE | CATEGORY | THEME |
|--|---------------------------------|--|
| Assess learners Assess and adapt environment Monitor learners' progress Provide ongoing support | Therapists' roles with learners | Barriers and facilitators related to therapists' roles |

| CODE | CATEGORY | THEME |
|--|---|--|
| Therapist part of TST Access curriculum Train educators Adapt curriculum | Roles with educators | Barriers and facilitators related to therapists' roles |
| Capacity development | Roles with students/therapists | |
| Communication School community Farmers | Networking | |
| Direct or indirect support in the community? What facilities? Uncertainty | Therapists unclear about roles | |
| Lack of skills: uncertainty Therapists as experts: confidence Discontinuation of training Staff changes | Therapists' skills | Barriers and facilitators related to intrinsic factors |
| Frustration Feelings of powerlessness Feelings of guilt | Therapists' negative emotions | |
| Lack of human resources Lack of time as a barrier Time not a barrier if consultants | Prioritisation of time | Barriers and facilitators related to extrinsic factors |
| Recognition: therapy related courses No financial support | Cost of capacity development | |
| Peer support Meetings | Support factors | |
| No communication Two circuits Two managers | Circuit boundaries affecting communication: barrier | Barriers and facilitators related to the district-based support team |
| Roles at ordinary school Roles at full service school Communication problems | The role of learner support educator: facilitator | |

| CODE | CATEGORY | THEME |
|---|---|---|
| Rejecting ideas for community projects Lack of trust Repressing therapists growth School is losing expertise | As a barrier | Barriers and facilitators related to the principals |
| Motivate and organise projects OT's success due to principal Developed Nu Thera Taking active leadership roles | As a facilitator | |
| Misunderstanding: therapists' roles Re-inforcing each other's work Team effort to provide support | Relationships educators/therapists at the special school | Relationships with the educators |
| Initial scepticism to change of attitude Educators eager to learn Willing versus unwilling educators Stressed educators Educators not knowing if school is FSS Training to educators | Relationships educators/therapists at the full service school | |
| Parents' meetings Supportive home environment Learner's integration | Role of the parents | Relationships with the parents |

4.5.1 Barriers and facilitators related to therapists' roles

Therapists indicated that they played important roles in relation to the learners, the educators, the student therapists and networking in the community. They were unclear about their roles in providing support to the ordinary and full service schools.

4.5.1.1 Therapists' roles in relation to learners

Therapists' roles in relation to learners involved the assessment of learners, assessing and adapting the environment, monitoring the learners' progress and providing ongoing support.

Occupational therapists were involved in the assessments of learners with learning disabilities, but the focus of the assessment was to provide the educator with advice to help the learners or for placement in the ordinary school.

U:but at the moment we are at a place assessing what the needs in that school [Full Service School Blue] are now so that one can empower the educators to cope with what they have.

U: The child would have been here [Special School Blue] for some time and we would have assessed whether the child is ready to be placed in mainstream, based on their academic skills, and that is really the route.

Conclusion 1: Therapists' competencies, including knowledge and skills to do appropriate assessments, facilitated support provision to the full service school and the special school.

When learners were transferred from the special school to the ordinary or full service school, therapists usually visited the schools beforehand to consult with the educators and to provide their support by doing an assessment of the school and classroom environment.

D: If one of our kids has to be mainstreamed we normally go out to the school. Before the kids go, we go beforehand and speak to the educators.

Therapists at the special schools were involved in adapting the physical environment at the full service school to make it more accessible for learners with disabilities.

M: But we could provide for their immediate needs of the child by telling them: "this is where the ramp needs to go because he is on the trike and that's the way he moves around" and things like that, that so they [Full Service School Blue] definitely became a little bit more accessible.

Conclusion 2: Therapists' skills to make the full service school more accessible to learners acted as a facilitator to support provision.

Some therapists monitored the learners' progress for a certain period at the ordinary school. If the learners did not adapt successfully, the learners were readmitted to the special school. Therapists' attitude regarding this process of readmission was positive and they were willing to evaluate learners' progress to see if integration was successful or not.

U: We will follow the child to be placed up to a year for a trial period. I know initially in the past a child used to go to mainstream for a term and just see how things go and then either to be permanently placed and if unfortunately, things don't work out, they sometimes return.

Therapists were also prepared to provide ongoing support when the learners were successfully integrated into the ordinary school.

M: ... If the school needs support then we will come in, and say the management, maintenance, we will actually do that [Ordinary School Blue].

This seemed like a contradiction since therapists of the Special School Blue were not allowed to go out to the school community. However, on clarification, therapists confirmed that they did not go out but meant that they would intervene by doing the management and maintenance by giving advice telephonically. This also involved referring learners, who were attending ordinary schools, to the Western Cape Rehabilitation Centre if they needed assistive devices.

Conclusion 3: Therapists' availability to provide ongoing support when learners moved from the special school to an ordinary school acted as a facilitator to therapists' support provision.

4.5.1.2 Therapists' roles in relation to educators

Therapists' roles in supporting the educators sometimes involved being part of the Teacher Support Team at the ordinary school, accessing and adapting the curriculum, and providing training to educators.

One therapist was invited to become part of the Teacher Support Team so that she could act as a consultant and advise educators regarding problems they experienced with learners at the ordinary school.

L: Then there was the head of the TST [educator support team of ordinary school] at the district who contacted me [therapist at Special School Blue] just to become part of a TST. They had some problems with learners [at the Ordinary School Blue] and wanted to know what they can do.

Therapists played important roles in helping educators address barriers to learning and increase accessibility especially to the curriculum. One physiotherapist reported giving

advice to educators on how to adapt physical activities for learners at ordinary and special schools.

D: No, the only place we get involved in the curriculum is with the life orientation and that is with the mobility aspect [Special School Yellow].

Therapists from special schools were helping educators to adapt the curriculum at special schools, full service schools and ordinary schools to make it more accessible for learners who experience difficulties.

S: So I think this co-operation between the therapist and the educator with the curriculum is very important [Full Service School Red].

L: ... this was an athetoid. She couldn't access the curriculum with writing and we were just recommended what they do, you know, a computer or a typewriter [Special School Blue].

Conclusion 4: Therapists' skills and knowledge to support educators by adapting the curriculum and facilitating access to the curriculum acted as a facilitator to therapists' support provision to other schools.

Some therapists supported educators by providing training to the educators. This was done by giving talks to the educators in ordinary schools about learning difficulties and postural problems. Therapists organised workshops to provide information to educators and to develop their skills to enable educators to minimise and to remove barriers to learning. Educators in ordinary schools were eager to obtain information that would enable them to meet learners' needs in an ordinary school.

L: We were asked to do a training session or a workshop with regards to what we can offer the educators and then other problems came from them. They wanted to know what we can do with this child, what we can do with that child. Then it became individual questions on needs and how we as OTs or speech therapists can help at the ordinary schools.

Training enabled the educators to understand the roles of therapists in the ordinary school and how therapists could support them (the educators) with the learners' needs. Understanding and accepting therapists' roles in the ordinary and the full service schools will encourage the educators to contact therapists for assistance and advice.

Conclusion 5: If educators are open to accept therapists' support, it facilitates therapists' support to these schools.

4.5.1.3 Capacity development of student therapists

Some therapists were also involved in the capacity development and training of student therapists by mentoring and supervising them at the Ordinary School Red.

V. We also arranged that the students do one of their clinical blocks there at that ordinary school [Red] and they are doing a great job.

The positive arrangement between the Special School Red and the Ordinary School Red enabled therapists (occupational therapists, physiotherapists and speech and language therapists) and occupational therapy students to provide their support at the ordinary school. Because the therapists had a good relationship with the ordinary school, arrangements were made for occupational therapists to do their practical work at the Ordinary School Red.

Conclusion 6: This positive relationship between the Special School Red and the Ordinary School Red acted as a facilitator to therapists' provision of support.

4.5.1.4 Therapists' networking with school community

Some therapists reported that networking with the broader school community was important to supply them with the appropriate resources to meet the learners' needs. Keeping in contact with and informed about resources in the community (namely, other schools) would allow therapists to do the correct and effective placement of learners with disabilities in ordinary and full service schools. The school community includes other special schools, ordinary schools and full service schools.

L: I think also for us to be as effective, we need to know what is out there for our disabled, like the placement; it is important for us to know where the child is going, to see what's available there. So we actually need to make the connection with the mainstream.

Some therapists expressed their disappointment that they could not make more contact with the community. They said that the community needed to be informed what resources were available at the special school and it was the responsibility of the school to extend itself to the community.

M: ... and here we have the resources and yet we are not communicating with the community out there, which is for meWe actually, we as a school [Special School Blue] are so bad in that we are not even advertising ourselves.

Conclusion 7: If therapists are not informing the community of what is available at their schools, it creates a barrier to therapeutic support provision to ordinary and full service schools, because people will not use the facilities if they are not informed about what it has to offer.

At Ordinary School Red (a farm school), therapists used their networking abilities to arrange with the local farmers to provide the transport to bring the parents to school meetings. This resulted in well-attended meetings, during which therapists felt that they could convey valuable information and advice to the parents.

S: But the farmers brought them [parents]. We have a co-operation agreement with the farmers. All of them [parents] actually are staying on the farm.

Conclusion 8: The positive agreement between therapists and the farmers acted as a facilitator to therapists' support provision to the parents.

4.5.1.5 Therapists unclear about roles

Some therapists were unclear about their roles when providing support to ordinary schools. Therapists were uncertain as to whether they should give indirect support (consult with educators at other schools) or direct support and where this would be done. Therapists from the Special School Yellow were unsure about the facilities they would be using at the ordinary and full service schools.

E: I mean even as we go out to schools, if they are going to implement that, are we going on a consultation business? Are we acting as consultants? Are we going there and having to treat the child? Where do we do it?

E: But what do they want us to do in the community? Do they want us to do what we do in the mainstream school? They just need to be a little bit more specific what they want us to do in the community.

Conclusion 9: If therapists do not have clarity about their roles, or whether they are expected to do direct or indirect support at the ordinary schools or the schooling community, it forms a barrier to their support provision to other schools.

One physiotherapist indicated that it was expected of them to become more involved with the curriculum, but expressed her lack of knowledge and her inability to adapt the curriculum.

N: ... as physio's we've been told constantly at educational level, EMDC level, we need to get more involved with the curriculum, but we actually do not know what and how.

Conclusion 10: If therapists do not familiarise themselves with the curriculum and its outcome levels for each learner's needs, it creates a barrier to efficient support provision to educators in all schools.

4.5.2 Barriers and facilitators related to intrinsic factors

Therapists indicated that there were intrinsic factors within themselves that either prevent them from providing their support or motivate them or make it easy for them to provide their support to mainstream schools. The intrinsic factors that caused barriers or facilitators within themselves were therapists' skills and therapists' negative emotions.

4.5.2.1 Therapists' skills

Therapists indicated how a lack of skills can act as a barrier and how their confidence in the skills they have can facilitate their support provision.

Therapists recognised the need to train educators but also felt that they were not equipped to fulfil all aspects of the consultative roles and wanted to learn skills to be able to facilitate workshops.

N: We would have liked to hold a workshop to facilitate skills training for educators—just simple skills.

Conclusion 11: Therapists' lack of skills to run workshops for educator training acted as a barrier to the support provision for educators in ordinary and full service schools.

Other therapists also expressed the need for advanced training in their specific fields.

M: Yes, the thing is not so much just doing assessments; you know, that kind of thing, it's more consultative as well as your training workshops and even though we are equipped to do

that, it would be nice and to advance our skills, to actually be given training. That is the other thing.

Conclusion 12: Training for therapists was an important facilitator or supporting factor in providing therapists with the necessary skills and knowledge to be consultants.

Therapists expressed confidence in being experts in adapting the physical environment, but also admitted not knowing everything and indicated their willingness to learn from the educators.

M: We are experts as far as the environment is concerned. But we can also learn a few things from them [educators].

Conclusion 13: Therapists' confidence in themselves as specialists in their own field and a positive attitude to learn from educators contributed to facilitating support provision to other schools. However, a lack of confidence can be ascribed to a lack of skills and knowledge, which acted as a barrier towards their support provision.

At Special School Yellow therapists had received some training but it was discontinued. As a result, therapists experienced a lot of uncertainty.

D: there are lots of things we are not sure about: we know what was expected of us but we don't know how to do it. We did have a few workshops but I don't know, wasn't fruitful.

D: Yes, that was initially and then everything just faded out. There were changes at EMDC level and people that were supposed to support us in the process. Changes in the staff, and there was never any follow through.

Conclusion 14: Key personnel at the EMDC had acted as important facilitators for the guidance of therapists until their posts were vacated. Lack of training prevented therapists providing their support to other schools.

4.5.2.2 Therapists' negative emotions

Therapists indicated that their negative emotions, which acted as barriers to their support provision, were frustrations, feelings of powerlessness and feelings of guilt.

Therapists' frustrations were caused by the district-based support team not providing proper guidance and training to facilitate support provision and delaying response when therapists

had requested a full service school to work with. Other frustrations were caused by educators' different service expectations, educators not listening to their advice, and the lack of policy at school level.

Therapists were particularly frustrated when educators at the Full Service School Red expected them to provide direct support instead of indirect support. Some therapists from the Special School Red decided to provide direct support for learners in one project at the Ordinary School Red, since they had the resources to share. The therapists of Special School Red felt that their social responsibility compelled them to share their resources with a neighbouring school (a farm school) that was in need. They envisaged their roles at the Full Service School Red as completely different, and this called for an indirect or consultative approach. However, therapists found that giving direct support at the Ordinary School Red (a farm school) created problems for them, since the educators at the full service school expected the same type of support (direct support). Therapists indicated that the learner support educator, who was working at both the ordinary and full service school, might have informed the full service school on the service provision at the ordinary school, which might have caused the conflict.

S: Some of them expect of you to go in there and render a service.

V: I think that's the situation at the Full Service School Red at the moment because some of them, not all of them, expect direct treatment.

Conclusion 15: A barrier to therapists providing their support was created when educators expected a different type of service to what therapists had in mind.

Therapists felt frustrated when educators were not listening to their advice. Therapists felt that educators in Full Service School Red did not want to listen and follow their suggestions. Therapists indicated that educators misinterpreted the therapists' guidance, with educators feeling that they were being viewed as incompetent to do their own work effectively.

T: Educators feel threatened by the therapists coming into the classroom and doing something, because that to them implies that you are saying that they don't know what they are doing or they don't read you correctly..... They are not open for learning. They might not scaffold or grade something correctly and that's what you are trying to teach them. They are then not open for that and then that's a bit of a barrier.

Conclusion 16: Poor communication may have caused this misinterpretation and resulted in the power struggle between therapists and educators. Poor communication between therapists and educators acted as a barrier to therapists' support provision.

V: I can think of two educators there now who say that we want to take over their role and say they are bad educators, and that is a bit of a problem.... I think that is a bit of a barrier because if your educator is not working with you, then you've already failed.

Conclusion 17: Therapists reported that when educators did not provide their co-operation, they (educators) acted as major barriers and therapists were unable to provide their support to them.

Therapists indicated that the lack of policy at school level was one of the major causes of their frustrations.

Therapists at Special School Blue experienced frustration when the Principal Blue was using technical excuses to stop the therapists from going out to the community. Principal Blue prevented therapists at the special school from going to the ordinary schools because there was no policy in place permitting them (therapists) to do projects in the community. The principal wanted a policy as a "backup" if anything went wrong while therapists were in the community. Since no such policies were in place at the school, therapists were not allowed to go out to the community. School policy is developed within the school. This poses a question as to why, if the principal felt that a policy was necessary, she has not developed one. The principal acted as a barrier in preventing therapists from providing their support to other schools.

K: You get the book thrown at you. These are procedure and these are the sticks. And have you thought of the implications and all about the red tape, procedure and the fact, the policy is now sacred? Before anybody can go out there, or any of the therapists, now there must be a policy in place.

According to therapists, policy at school level had become more important than policy at national level. Therapists at Special School Blue experienced resistance when attempting to start new projects in the community. This created conflict over policy at school level.

When asked about the Education White Paper 6 that is in place, the therapist responded:

M: No, that's not the policy that Principal Blue wants, because Principal Blue knows about the policy, we know about the policy and we all went for training. But Principal Blue wants the policy that if something goes wrong tomorrow the Principal Blue can say: "I am backed by this policy".

Conclusion 18: The lack of policy at school level created a barrier preventing therapists providing their support to other schools.

Therapists indicated that they experienced feelings of powerlessness due to autocratic leadership styles and because they did not form part of the district-based support team.

Some therapists reported that the problems or barriers they experienced, which prevented them from giving support to other schools, do not come from grassroots level but from higher positions, namely, the principals and managers at district level. Therapists felt that they have not been involved in decision making and that leadership styles are autocratic, which has left them with a sense of powerlessness.

M: ... it's not your people on the grassroots here, it's actually higher up where you can see what they think and how they think and how they do things.... no matter how democratic the system may seem, they are actually autocratic.

The therapists indicated that in spite of the written policy (Education White Paper 6), inclusion has not been visible in practice. This is because the principals and the managers, at the district level (due to autocratic leadership styles), were forming the barriers to practicing inclusion. Therapists felt that principals and managers at district level were making decisions on their own, excluding therapists and giving therapists a sense of powerlessness.

K: Not only the principals but, the district level. The policy is there, we got White Paper 6, and we got inclusion. That shows to what extent the barriers to practicing inclusion lie in the district and principals.

Conclusion 19: The autocratic leadership style of principals and managers at district level acted as a barrier to therapists' support provision to other schools.

Therapists said that they are supposed to form part of the district-based support team. The therapists expressed feelings of uncertainty and powerlessness because they were not part of the district-based support team.

S: But theoretically we should be involved in the district-based support teams. As far as I know, we haven't been drawn into the district-based support team from this school.... We don't really have any power on what they decide or are doing.

Conclusion 20: The exclusion of therapists from the district-based support team formed a barrier to their support provision to other schools.

Therapists from Special School Blue reported feelings of guilt when they had to go out of the special school to serve the community. They have the perception that because the Western Cape Education Department is paying their salary, their first priority should be with the learners at the special school. The therapists perceived it as ethical problem to leave the school to go out into the community.

M: That is where the ethical problem lies; we are based at the school. We are responsible for the learners at the school [Special School Blue].

Therapists felt that if they were to be based at district level, their feelings of guilt would be removed. Their feelings of guilt were related to the obligation they had towards the school and the learners at the special school. Therapists' perception is that being based at the district level and being part of the district-based support team would provide them with more freedom to move around to provide their support to other schools.

M: But if we are based at the district level, I do think then that's what we do and we don't have to feel guilty about leaving the place because you actually are being paid by WCED to be with the learners.

This reflects confusion on the therapists' part because the Western Cape Education Department employees are supposed to give support to all learners in any government school or facility in the district. If they are going to be based at the district level, they will still be paid by the Western Cape Education Department.

Conclusion 21: However, therapists indicated that being based at the district level would facilitate their service provision to the special school, the full service schools and the ordinary schools in the vicinity. Being based at the special school was perceived as restrictive and as a barrier to their support to other schools.

4.5.3 Barriers and facilitators related to extrinsic factors

Extrinsic factors influencing therapists' support provision included the cost of capacity development; lack of human resources, which had an impact on therapists' prioritisation of time and on the type of support provision to ordinary and full service schools. Some therapists indicated that lack of time was a barrier, whereas others disagreed and claimed that time need not to be a problem. Extrinsic factors that provided support to therapists were meetings with educators, meetings with other therapists in the district and peer group support.

The costs of training have demotivated therapists to do continuous professional developmental courses that can improve their skills.

The Western Cape Education Department (WCED) does recognise postgraduate degrees with financial compensation for educators. However, therapists at the Special School Blue felt they had been neglected in this regard as their discipline-related courses are not recognised by WCED and that they receive no subsidy to finance their courses. Therapists must finance their own courses, sometimes up to R4000 per course, although therapists use the knowledge and skills in their own school community. Therapists thus experience no support financially to further their education.

M: Ja, I don't know whether it is financially driven, whether it's, you know, that kind of financial worry in them paying for the training. If they would say "OK, you are a brilliant OT [occupational therapist] with NDT [Neurodevelopment Therapy], now we can up your money a bit: you know, your salary. But they don't even do that for you; but it is given to the educators. So it's the financial support, it's the training we need; something that we can actually use for the broader community in education.

Therapists were not encouraged by Western Cape Education Department to do relevant courses in their fields if they were not supported financially. A barrier was formed if therapists were not involved in continuous professional development. It also influenced the quality of support provision to the school community (special, ordinary and full service schools).

Conclusion 22: The cost of financing their own training acted as a barrier to therapists' support provision to others.

Therapists indicated that due to a lack of human resources, they were acting as consultants when providing advice to educators in the special schools, ordinary schools and full service schools.

A: ... because we are not enough therapists, we, on a consultation basis, say if educators [in Special School Yellow] would come to us with a child, then we could give them some tips, ideas on what to do in the class, etc.

Some therapists reported that they will not have the time to provide their services to both the special and the full service schools unless there are more therapists. They indicated that they could not even treat all the learners at the special school, let alone go out to the full service school to provide their service there.

C: You have so many hours in the day and so many learners and to be effective you need to see them often enough.

A: Okay, the first one is probably manpower. It's not enough, we do all we can, we can't see all the learners; you don't even get to see all the learners. We are only allowed to see them once a week and they don't actually benefit.

However, other therapists at other special schools said that time should not be a barrier to going out to full service schools even if it is once a term or a month, one hour after school. These therapists felt that an hour is sufficient to have successful networking and to act as consultants in the schooling community.

L: You know what, even if it is one step at a time and you have a sort of a plan, where it's like once a term, like it's a set thing. And you know what? Even if it's once a month, it can happen because you are only taking one hour of your time after contact. I'm talking about you going to leave early for transport, you feel so much, in that hour you've reached more people, you've connected more, and you got more of those networking, man!

Other therapists from Special School Red also reported that networking and reaching out to the ordinary schools were not difficult in terms of time. These therapists indicated that spending two and a half hours per week at the Ordinary School Red was sufficient to deliver their support.

V. We go there every Friday for two and a half hours.

Therapists reflected different attitudes to use of time. The experience of time as a barrier will depend on how activities are prioritised. Human resources can be used effectively, depending on the type of support provided at the different schools. Due to the shortage of human resources, therapists at special schools need to consider using more indirect or consultative input when providing support to educators in other schools.

Some principals were reluctant to send therapists out to the community because of the shortage of staff and a lack of policy, while other principals accepted that the school had a responsibility to the community.

S: It was more difficult with our previous principal. We were less and his argument was that we aren't enough. How can we reach out? But when we became more that argument wasn't valid anymore. Therapists had the need to do this even in that time. In fact, we had started doing it in that difficult time when we were not enough.

Some therapists were optimistic and felt that a school with a small number of therapists should not be a barrier that would stop them from providing their support to ordinary and full service schools.

Conclusion 23: Therapists' optimism acted as a facilitator to their support provision.

Therapists reported that meetings, as a tool for communication, had been valuable and had acted as an important factor in enabling therapists to provide their support to the full service school. Meetings with key role players at the Full Service School Red provided an opportunity to discuss problems and to evaluate if therapists were on the right track regarding their support provision to the full service school.

T: I think it is very important. If it weren't for these meetings we might not have picked up on possible problems. It is important evaluating what you are doing and to get an idea of what is right or wrong.

Conclusion 24: Therapists' meetings with the personnel at the full service school acted as an important facilitator to therapists' support provision to the full service school.

Some therapists claimed that they only experienced support from their peers. The therapists of the special schools for learners with severe intellectual disabilities said they met on a regular basis to support each other.

K: The support that the therapists have, comes from something they have created for themselves. Like the therapists in the SMH schools (Severely Mentally Handicapped Schools); they meet regularly to support each other professionally.

Some therapists felt that their experience with the Full Service School Red was not only new to them but was also a new experience for the personnel at the Full Service School Red. Therapists felt that the therapists in the different districts should share their experiences so that they could learn from one another.

U. I think also our relationship with Full Service School [Red] was something new to the school and to the Full Service School [Red]. I'm sure in the other EMDC's they've possibly done a similar study or intervention and I think that if we start sharing about what's happening on that side, that can also make the road easy. Educators will understand better what's coming and what's not coming, the same with us here.

Conclusion 25: Meetings with other therapists from other districts can act as an important facilitator for the support provision of therapists to other schools.

4.5.4 Barriers and facilitators related to district-based support team

Therapists indicated that the district-based support team could act as a facilitator by co-ordinating therapists' support provision and the role the learner support educator played. A barrier was formed when circuit boundaries affected communication between the special school and the full service school.

One therapist maintained that the district-based support team had a potential role for facilitating support provision by co-ordinating resources optimally.

Conclusion 26: The district-based support team could act as a facilitator to effective provision of support by co-ordinating therapists' activities at the full service school.

K: For these kinds of outreaches to work efficiently and effectively you do need co-ordination from district level. Otherwise we are doing this here and somebody else is doing that there; you need some sort of broad overview so that resources are being used optimally; if it is co-ordinated also by the principal and the district.

Conclusion 27: The learner support educator played a very important role in facilitating therapists' support to a full service school.

Some therapists in one group had the opportunity to develop a good relationship with the learner support educator from the district-based support team, during their first community project at the Ordinary School Red. The learner support educator facilitated the therapists' support to the Ordinary School Red. She was also the link between the therapists and the district-based support team and was allocated to both the ordinary and the full service schools. The learner support educator's role at these schools was to provide extra learning support to learners who had learning problems. When the therapists had to start their second project at the Full Service School Red, the learner support educator was of great help when therapists experienced difficulties in terms of communication problems. Therapists felt that the learner support educator understood the roles of the therapists and she could explain their roles to the educators at the full service school, especially from an educator's perspective, thus helping to lay the foundation for their work at this school.

S: She was involved when we initiated the project at Ordinary School [Red] and she also then helped us with the groundwork when we really got stuck and involved in Full Service School [Red]. So that, I think is very important to have someone who in general is involved in both projects. It really helped us that there was somebody who could identify with where we are coming from, and knows what we want to do. Ja, that was a big benefit to us and to the school.

Conclusion 28: The relationship with the learner support educator indicated a positive relationship with the district-based support team, which acted as a facilitator for therapists providing support to learners in the full service school.

Therapists mentioned that the Special School Red, which was developing into a resource centre and the Full Service School Red, that they were supposed to support, were situated in two different education circuits. This created a problem for them in giving support to educators in the full service school. The two circuits had their own circuit team managers and, according to the therapist, they were not communicating with each other.

K: The problem is that the Full Service School [Blue] and Special School [Blue] lie in two different circuits. Two different managers ... and I think that's where the breakdown is. The circuits are working on their own and they are not talking to each other.

Communication between the therapists of the special school and the personnel of the full service school was essential for the exchange of knowledge and skills. A relationship

between the special school (resource centre) and the full service school was important for therapists' support provision.

Conclusion 29: A barrier to therapists' support provision to the full service school was created when the personnel of the two schools were not communicating with one another because of circuit boundaries.

4.5.5 Barriers and facilitators related to the principals

Therapists indicated that the principal acted as a facilitator by encouraging therapists to provide their support to other schools and as a barrier by preventing therapists' support provision.

4.5.5.1 Principal as a facilitator

Therapists indicated that one of the major support factors that facilitated therapists providing their support to full service schools was when the principals of the special schools were actively involved. According to the therapists, projects usually were more successful if the driving force came from the principal who motivated and organised the project.

M: There are three schools that came together, used their therapy department, and educators as well. They actually have gone out to service other schools and they are actually doing brilliantly. But then again their principal was on board and he saw to the training.

For example, when an occupational therapist had successfully given her support to ordinary and full service schools, this was ascribed to the important role the principal had played. Although the occupational therapist was employed for only a short period, she achieved a lot because the principal was supporting her. Even when this special school did not have an occupational therapist, the principal continued networking with other schools to obtain the resources when she needed them.

M: In the short time she's [occupational therapist] done so much, but the principal is extremely interactive.

Principals also played a supportive role in developing Nu Thera, a support structure for therapists and nurses who were working at special schools.

M: This Nu Thera thing has also been created by therapists but with the help of two principals. And in this case our Principal [Blue] actually was part of the initial team who actually brought Nu Thera where they are at the moment. They were there from the start and she did encourage a lot of things for the therapists and the nurses, but to the point when now we are on our feet.

One therapist reported that the two principals at the Ordinary School Red and Full Service School Red did not assume an active or leadership role, as far as in these schools' projects were concerned. The principals were allowing the support to happen and not obstructing it. However, the therapists would have liked the principals to take a leadership role in the project and to have encouraged more educators to become involved. The co-operation of educators is important for therapists in providing their support.

S: The one thing is, I think both the principals [Principals Red at the ordinary and the full service schools] are quite passive and I think that's, it can be very difficult; but in this case their passivity is actually not making it difficult. They just let it happen, they are not active. Our principal [Special School Red] is also not involved but he encourages and supports these projects.

Conclusion 30: The active role of the principal is important to facilitate therapists' support provision.

4.5.5.2 Principal as a barrier

Some therapists indicated that Principal Blue had a problem with their ideas regarding community projects at ordinary schools and would not support them. Principals can form a barrier to therapists' support provision to other schools by refusing permission to therapists to be involved in community projects at other schools.

M: And any community project that you want to start gets shot down before you even start Because of the principal [Blue]; it gets shot down because of the principal [Blue].

K: You come out with a wonderful idea and say, because that's the right thing to do, just let me run by the office. And then it gets shot down.

Therapists suggested that Principal Blue did not trust them because she feared that if the therapists failed, this would be a bad reflection on her.

M: The impression you get is: “I [Principal Blue] know it’s going to fail. I’m [Principal Blue] not going to give the opportunity, because I know it’s going to blow up in my face. I’m going to look bad”. So how then are we going to get experience of failing and moving and succeeding and knowing we are now tops? How do we get there?

Some therapists acknowledged that they may make mistakes when attempting community projects but saw it as part of the growing and learning process. Therapists expressed the desire to provide their support to other schools and to learn from other people. They said they needed to be trusted by the principal when doing these projects.

L: I think there is a lot of trust also involved. I’m a professional. I know I’m going to make a success. I may err, and you go through that, that’s the growth. We take five years before we go out. I want to go out there. Yes, how are we going to get there if ... I want to learn; I want to make the mistakes; I want to see where to now. I want to learn from other people; I want to get that other info.

Some therapists at the Special School Blue reported that the Principal Blue was repressing their growth. Therapists also felt that they always had to give something and prove themselves in order to receive anything they were asking for. This had a demoralising impact on the therapists, with the result that therapists were leaving the school because no opportunities were given to stimulate their professional growth.

M: It is too overprotective. We need to give a little bit in order to get something. And if we don’t give, we are not going to get and that is where we are at the moment. I mean we are losing the expertise here simply because nothing been given to us to enrich ourselves.

Conclusion 31: The principal who did not give support to the therapists acted as a barrier to therapists’ support provision to other schools.

4.5.6 Relationships with the educators

Therapists indicated that their relationships with the educators in the special schools and full service schools had an impact on their ability to deliver their support to these schools. Therapists indicated that factors that affected their relationship with the educators in the special school included misunderstanding of therapists’ roles and their team effort to provide support. Some therapists said that they had built a positive relationship with the educators at

the special school after initial misunderstandings about the therapists' roles. However, eventually, educators came to a better understanding of what therapists can do in a school and how the learners' needs could be met.

M: So now we are starting to understand each other's roles better, we appreciate each other better, because we can complement them and they can complement us. So in actual fact the intervention is much more holistic. It's been reinforced either with the OT and the educators. So the child is learning and showing progress in that way.

Therapists from the Special School Blue reported that because of a positive relationship between educators and therapists at the special school, both professionals can work together as a team, thus acting as a facilitator to provide support to the ordinary schools.

M: I do now think that our own educators are equipped enough to actually show their expertise to the educators out there. And we can actually help support each other by taking our expertise and going out there to the mainstream, which is what we should be doing.

Therapists indicated that the factors that affected their relationships with the educators at the full service schools included educators' attitude, educators being stressed, educators not prepared for full service school and training to educators.

Therapists at Special School Blue reported that when they initially went to Full Service School Blue, educators appeared sceptical and threatened by their presence. The educators' attitude changed when they understood the therapists' purpose was to provide support and to create a more accessible physical environment for learners with physical disabilities, to enable learners to move around the school.

M: Full Service School [Blue] was initially very anti having us there because they thought that we are going to change their entire environment and setup but until they realized we were just talking about the accessibility, like environment for the learners, and then they realised that we were not taking over their school.

When educators understood therapists' roles in the school environment, they were more open to therapists' input.

Conclusion 32: Understanding of and knowledge about therapists' roles changed their attitudes and facilitated therapists' support provision.

Therapists indicated that most educators were eager to learn and wanted to know more.

U: Some educators are very open to learning and understand what our roles are, others are less open, but generally [at Full Service School Red] we have a very positive attitude.

In another group interview, therapists described their relationship with educators as very good. The interaction between therapists and educators became positive when educators could see the value of therapists.

Conclusion 33: A positive relationship between therapists and educators (ordinary schools and full service schools) acted as a facilitator for therapists providing their support to other schools.

L: So what we do is to assess and consult with the educator [ordinary school] and we also give a report.... and the educators have said they actually find it invaluable. They loved it! Because it makes them see the child differently and become a little more patient with the child because they realize that actually ... it's for those reasons that the child is struggling in a particular area. It also helps them then for their portfolio because they see the child in a more holistic way.

On the other hand, therapists indicated that the educators at the full service schools saw the classroom as their own domain and would not easily allow changes in their classrooms.

M: But they still actually are not very open to you coming into the classroom telling them certain changes must be created there.

Conclusion 34: Therapists indicated that educators' inflexible attitude formed a barrier to providing support.

Some therapists described how starting the project at Full Service School Red was difficult since some educators were not willing to co-operate. One strategy was to start with the educators who had a positive attitude and then hope that the unwilling educators would eventually be drawn into co-operating with the therapists. The therapists' vision was not necessarily shared by all educators. For example, therapists wanted to provide their support starting at Grade R at the Full Service School Red, but had to start with Grade One since the Grade R educators were not willing to participate in this project.

S: But I think the difficult times you must just work through there. We also initially said, let's start with the educators, in the classes of educators that are willing to have us there and the Grade R educator wasn't willing, which is actually the correct place to start so we started in Grade One; but I think wethe purpose was to start working with the educators who want to do the intervention and then as the word is spread you can continue with the others.

Conclusion 35: If educators are unco-operative and do not agree on the same principles, it becomes a barrier for therapists providing their support to those educators.

Therapists wanted to offer advice so that educators would be able to teach the learners in a different way, that is, to give them a more effective teaching approach that would benefit the learners. However, some educators perceived it as extra work, whereas the therapist's purpose was to alleviate or make the educator's task easier. It is possible that the educators were too stressed to take in more information even if the therapists were saying useful things. This may indicate that therapists should consider a different approach such as stress-reduction techniques in order to be heard. However, the therapists' approach could have been perceived as being "bossy" and adding extra work to their already overwhelming task.

T: Look, if you are now saying: "Maybe you should try this or that way", they [educators at the Full Service School Red] think you are giving them something more to do, not making their life easier or giving them a different strategy. You are actually telling them to do something more and they are already so overwhelmed.

One therapist reported that full service schools were just chosen without the personnel's input. Therapists felt that full service schools were not given sufficient preparation time to orientate the personnel about the basic concepts of inclusive education and the function of the other important role players, namely the therapists from the special school resource centre.

S: Schools were just identified. Schools weren't asked: "who wants to be full service schools?" Schools were just identified as full service schools. Schools were, I think, being anxious and not knowing what is going to be expected of me and not understanding what the meaning of the concepts are. The road was supposed to be longer before information was given, to make sure people did understand the concepts and to get to know the people they are going to work with.

Conclusion 36: If educators at the full service schools had had more information about their own roles and those of the therapists in a full service school, it would have facilitated the support provision of the therapists to the full service school.

When learners with disabilities were accepted at the full service schools, therapists did some training with the educators, thus building positive relationships with them. Therapists found that some educators at the full service schools were very helpful to the learners, by giving advice that could facilitate the learners' adaptation.

D: When you go into the schools, you actually tell the educator these are the problems that you might experience. They usually are fine with accepting the suggestions and they will come forward and say, "you know the child can maybe go out to break a little bit before the other learners, have the toilet privately", you know, little things, and maybe I can get someone that knows the child just so that he can have a friend.

Conclusion 37: The training of educators, and the way therapists developed a relationship with the educators at the full service school, acted as facilitators to therapists' support provision.

4.5.7 Relationships with parents

Some therapists reported that they usually met the parents when learners were accepted at the special school. They reported that, afterwards, only two or three parents showed continuous interest in their children's activities. This formed a barrier since therapists could not build a relationship with the parents when they needed to advise and educate parents about the learner's condition.

N: We have parents' evenings [at the Special School Yellow] but then the parents don't attend. Parents are not really interested. It's a very small percentage of parents that would attend. On admission, when the child is admitted to the school, that's the only time we get to talk to parents. I have two or three parents that come to see me at school that are really interested in their children.

Parents' supportive roles in their children's lives affected the outcome of therapists' support to learners. Parents needed to continue therapy and make adjustments at home. If they did not continue with the activities, the support provided to the learner would not be adequate. Therapists reported that they had found that if the parents provided a supportive home

environment, the learner's integration in the ordinary school or the full service school was usually successful.

M: But thus far, for example this boy K, who is mobile on a trike [tricycle] was integrated successfully into the ordinary school.... But their own support, in the home environment was actually very good. So he could mould into, you know, integrate into the mainstream quite easily.

Conclusion 38: Supportive parents acted as a facilitator to therapists' support provision and, conversely, where parents did not keep in touch with the therapists, it acted as a barrier to therapists' support provision to the learner.

4.6 Summary

In Section B, the results of the analysis of the group interviews were presented. The demography of participants was described, followed by a description of the background to the three different group interviews. Different themes emerged in relation to the objectives, related to the barriers and facilitators that therapists from special schools experienced in providing their support to the ordinary and full service schools.

The themes were the barriers and facilitators related to the therapists' roles, barriers and facilitators related to intrinsic and extrinsic factors, barriers and facilitators related to the district-based support team, barriers and facilitators related to the principals, the relationships with the educators, and the relationships with the parents.

In the next chapter, the discussion of the results will be presented.

CHAPTER FIVE

DISCUSSION

5.1 INTRODUCTION

In this chapter, a discussion related to the research questions is presented: Question 1: Are therapists using a medical model of support or a health-promoting model of support to develop an inclusive education system? Question 2: What are the barriers and facilitators therapists experience regarding therapists' support provision in an inclusive education system? First, Objective 1, in Section A, namely, to explore whether therapists are working in a medical model of support or in a health-promoting model of support, is discussed. The re-orientation of support services, indicating a need for change of model of support, is then discussed. Objectives 2 and 3 are then addressed in Section B. Objective 2 was to describe the barriers to therapists' support and the influence on therapists' support provision to ordinary and full service schools. Objective 3 was to describe the facilitators that promote therapists' success in provision of support to ordinary and full service schools.

In the following section, the model of support is examined by using the five strategies of the health-promoting schools framework.

5.2 SECTION A: MODEL OF SUPPORT

The re-orientation of support services is one of the five strategies of the health-promoting schools framework. In this section, a discussion follows regarding the need for the change of model of support internationally and in South Africa and a comparison of the findings of this study with those of Struthers (2005b).

The findings of this study indicate that therapists are using the medical model at the special schools, but with more indirect support. Therapists have become more involved in activities that use a health-promoting approach by providing indirect support to the educators, creating supportive environments, developing personal skills of all in the school community, strengthening community partnerships and influencing policies. The findings of an analysis of the therapists' roles, regarding direct and indirect support, were compared with the study of Struthers (2005b), and a slight change was shown in the balance between direct and indirect support, inclined towards indirect support, but not indicating a major change.

The comparison between findings of this study and that of Struthers (2005b) is done because the same questionnaire was used in both studies. Struthers' questionnaire was administered in 2001 and the questionnaire for this study was administered in 2008. A comparison is done to look at the change of the model of support being used by therapists over the seven years. Struthers (2005b) found that direct support was the main form of support (68%) and indirect support was used to a lesser extent by therapists at the special schools (32%). The results in this study indicated that therapists were using more direct support (62%) than indirect support. Because therapists did not answer the question correctly, the total percentage of time spent on direct support and the activities of indirect support did not add up to 100%, making it difficult to interpret the most recent results (See Table 4.20).

In Struthers' (2005b) findings, therapists indicated that they wanted to decrease their direct support but the majority were not eager to increase their indirect support. In this study, therapists also indicated that they were providing more direct support than indirect support. However, they wanted to change by increasing the indirect support as well as increasing the direct support. This is not a practical solution since direct care is more intensive and time consuming and therapists will not have sufficient time to focus on indirect care. This will create more problems, in terms of time management, when therapists must provide their support to the ordinary schools. This demonstrates that most therapists were predominantly focused on direct support.

In the USA, operating in the medical model was identified as a problem when therapists working in the public schools continued to provide direct therapy, focusing on medical goals instead of education-orientated goals (Dunn, 1990; Jirikowic et al., 2001; Levangie, 1980; Royeen, 1986). The focus on the use of direct support can be attributed to the training therapists receive at the tertiary level, which concentrates on the individual hands-on approach used in medical facilities (Struthers & Lewis, 2004). Therapists in the USA (Rapport, 2002) and the UK (Lacey & Lomas, 1993) were mandated by legislation in the late 1970s and 1980s to change their focus of support. Legislation encouraged therapists to work in a more collaborative and consultative manner (Lacey & Lomas, 1993; Prigg, 2002; Rapport, 2002; Simmons Carlsson, 2002). The medical model has proven to be costly since it requires a large number of therapists to provide one-to-one interventions (Levangie, 1980). According to Struthers (2005b), direct support still has a place but it needs to be balanced with more indirect support.

According to the Department of Health (2000), the re-orientation of support services refers to a major shift from a curative, problem-orientated approach to a more preventative, health-promotional and developmental approach. Therapists can play an important role in removing barriers to learning by using the five different aspects of the health-promoting schools framework, namely, developing healthy school policies, developing a safe and supportive teaching and learning environment, building school community networks and partnerships, developing personal skills of all in the school community, and the re-orientation of education support services (Struthers, 2005b). Because therapists focus on direct support in special schools, they need to re-orient their support provision to ordinary and full service schools by considering working in a more indirect and consultative manner (DOE, 2005a).

The authors of the literature consulted refer to the use of indirect models, such as consultative, monitoring and collaborative models, under circumstances where human resources are limited (Rapport, 2002; Sandler, 1997) and state that direct support is time consuming and costly but can address complex problems and has a place in support provision (Dunn, 1988; Struthers, 2005b). However, the Education White Paper 6 (2001) states that the main focus should be on more indirect support to learners, by consultation with educators and parents at the ordinary schools. A secondary focus is to provide direct learning support where necessary and possible, especially if institutional-level support teams are unable to respond to learning needs (DOE, 2005a).

5.2.1 Direct support

This section on direct support includes a description of the settings where therapists taking part in the study worked, the assessments of learners, the intervention or management by the therapists, the evaluation of the treatment, the multidisciplinary support team and the referrals outside the school.

5.2.1.1 Setting for therapy

The settings that therapists used most frequently for provision of support give an indication as to whether they focus on direct support or indirect support. The majority of therapists stated that they often gave their support to learners in school therapy departments and, occasionally, in the classroom or school playground. The majority of occupational therapists and speech and language therapists never worked at the learners' homes. The minority of physiotherapists provided therapy at the learners' homes. These findings may imply that

therapists are spending most of their time providing direct support to learners and do not have the time to provide their support at the learners' homes. These findings indicated that a smaller proportion of therapists provided therapy in the classroom, on the school grounds or in an alternative room in the school. These findings are similar to the findings of Struthers (2005b). This may imply that therapists are not yet ready to increase their support to educators in the classroom, or that educators are not ready to accept therapists in the classroom.

In the USA, legislation identifies the classroom as the least restrictive area to provide support to learners, and this is where therapists are encouraged to provide their support (Rapport, 2002; Swinth & Hanft, 2002). The least restricted area has been defined as “an appropriate educational setting most like that of peers without disabilities that meets the learning needs of the individual child with a disability. The term relates to the continuum of service delivery” (Swart, 2004, p. 236). If a learner is supported in the most natural environment, it is more likely to result in full inclusion, where the learner becomes a full member in the general education classroom (Kelleghew & Allen, 1996). However, Kaminker (2004) found that physical therapists in the USA strongly favoured direct services over indirect services, despite the recommendation to use a combination of integrated and isolated (direct support) models.

These results, demonstrating that therapists are using the school therapy room more often than the classroom or the school play grounds as the setting to provide support, indicate that therapists are mainly working in the medical model of support while providing direct support.

5.2.1.2 Assessment of learners

All the therapists in this study were involved in assessment of learners with a variety of impairments. Therapists were assessing learners for school readiness, admission to special schools, treatment by therapists, advice to educators and parents, and home programmes.

In this study, therapists (OT: 11%; PT: 0%; SLT: 92%) reported that they assessed learners with hearing impairment. In comparison to Struthers' (2005b) findings (OT: 8%; PT: 3%; SLT: 75%), the results indicate that an increase of 17% of speech and language therapists assessed learners with hearing impairments. In this study, therapists (OT: 13%; PT: 0%; SLT: 100%) indicated that they assessed learners with speech impairment. In comparison to Struthers' (2005b) study (OT: 11%; PT: 3%; SLT: 100%), analysis of the results suggests

minimal change. In this study, therapists (OT: 17%; PT: 0%; SLT: 96%) stated that they assessed learners with language delay disorders. When compared to Struthers' (2005b) assessment (OT: 14%; PT: 3%; SLT: 100%), the results suggest minimal change.

In this study, therapists (OT: 54%; PT: 0%; SLT: 4%) indicated having assessed learners with visual impairments. In comparison with Struthers' (2005b) study (OT: 36%; PT: 3%; SLT: 0%), the findings indicate that an increase of 18% of occupational therapists assessed learners with visual impairment.

In this study, therapists (OT: 91%; PT: 100%; SLT: 4%) said they assessed learners with motor impairment. In comparison with Struthers' (2005b) results (OT: 93%; PT: 100%; SLT: 24%), the results show that a decrease of 20% of speech and language therapists assessed learners with motor impairment.

In this study, therapists (OT: 67%; PT: 12%; SLT: 12%) reported that they assessed learners with intellectual disabilities. In comparison to Struthers' (2005b) study (OT: 54%; PT: 12%; SLT: 10%), the results indicate that an increase of 13% of occupational therapists assessed learners with intellectual disabilities. In this study, therapists (OT: 89%; PT: 8%; SLT: 40%) were shown to have assessed learners with learning disabilities. In comparison to Struthers' (2005b) results (OT: 93%; PT: 6%; SLT: 52%), the results indicate an increase of 12% of speech and language therapists assessed learners with learning disabilities. In this study, therapists (OT: 52%; PT: 0%; SLT: 24%) claimed to have assessed learners with challenging behaviour. In comparison to Struthers' (2005b) assessment (OT: 36%; PT: 9%; SLT: 14%), the results indicate an increase of 16% of occupational therapists and an increase of 10% of speech and language therapists assessed learners with challenging behaviour.

In this study, therapists (OT: 15%; PT: 60%; SLT: 12%) indicated having assessed learners with medical needs. In comparison to Struthers' (2005b) study (OT: 29%; PT: 39%; SLT: 14%), the results indicate a decrease of 14% of occupational therapists and an increase of 21% of physiotherapists assessed learners with medical needs.

In summary, amongst occupational therapists, an increase of 18% of occupational therapists assessed learners with visual impairment, an increase of 13% of occupational therapists assessed learners with intellectual disabilities, an increase of 16% of occupational therapists assessed learners with challenging behaviour, a decrease of 14% of occupational therapists assessed learners for medical needs. Amongst physiotherapists, an increase of 21% of

physiotherapists assessed learners for medical needs, amongst speech and language therapists, an increase of 17% of speech and language therapists assessed learners with hearing impairments, a decrease of 20% of speech and language therapists assessed learners with motor impairment, and an increase of 12% of speech and language therapists assessed learners with learning disabilities. These results indicate that speech and language therapists demarcated a clearer role for themselves and focused more on hearing, speech and language disorders.

These results indicate that the therapists questioned in this study were using the medical model of support using direct support with the assessment of learners.

In this study, the majority of therapists (OT: 76%; PT: 84%; SLT: 80%) claimed to have assessed learners for admission to special schools. In comparison to Struthers' (2005b) study (OT: 89%; PT: 79%; SLT:95%), the results indicate that a decrease of 13% of occupational therapists and a decrease of 15% of speech and language therapists assessed learners for admission to special schools.

In this study, the majority of therapists (OT: 96%; PT: 96%; SLT: 96%) said they assessed learners for treatment by therapists. In comparison to Struthers' (2005b) findings (OT: 96%; PT: 88%; SLT: 100%), the results suggest minimal change. In this study, therapists (OT: 87%; PT: 80%; SLT: 80%) reported that they assessed learners to give advice to educators. In comparison to Struthers' (2005b) results (OT: 86%; PT: 73%; SLT: 86%), the results suggest minimal change. In this study, therapists (OT: 80%; PT: 84%; SLT: 80%) stated that they assessed learners to advise parents. In comparison to Struthers' (2005b) conclusions (OT: 79%; PT: 79%; SLT: 81%), the results suggest minimal change.

In this study, therapists (OT: 54%; PT: 68%; SLT: 40%) reported that they assessed learners for the provision of home programmes. In comparison to Struthers' (OT: 50%; PT: 70%; SLT: 67%) findings, the results indicate a decrease of 27% of speech and language therapists assessed learners for home programmes. These results imply a reduction of speech and language therapists' support to parents, which is part of the health-promoting model of support.

In this study, a smaller proportion of therapists (OT: 30%; PT: 4%; SLT: 20%) reported that they assessed learners for school readiness. In comparison to Struthers' (2005b) findings (OT: 39%; PT: 6%; SLT: 38%), the results indicate a decrease of 18% of speech and

language therapists assessed learners for school readiness. These results may imply a reduction of speech and language therapists' direct support to learners.

These results indicate that the majority of therapists were assessing learners for direct therapy, that is, treatment by therapists. The majority of therapists also assessed learners to give indirect support to the educators and parents. This indicates that therapists used both the medical model of support and the health-promoting model of support by developing the skills of the educators and the parents.

For the inclusive education system to be implemented, the way learners are assessed and placed at special schools will need to be changed (DOE, 2008) because learners will have to be placed at ordinary and full service schools depending on their level of needs (Struthers, 2005b). According to the Department of Education (2008), there is generally a lack of involvement of teachers, parents and learners in the assessment process. Previously, and at the time of this study, the therapists and psychologists formed part of the team that assessed learners, without the input of educators, parents and learners, to be placed at the special schools. The current assessment practices fail to summarise the nature and the level of support needed. There is no system of assessment and identification in place that ensures consistency of screening, identifying and referring learners into special schools. This is reflected by the increasing number of learners being referred to the special school from their local mainstream schools. From 2004 to 2007, the number has increased by more than 15000 learners (DOE, 2008).

The National Strategy on Screening, Identification, Assessment and Support (SIAS) was developed to respond to these needs by including all role players in the assessment process (DOE, 2008). The SIAS strategy grew out of the Education White Paper 6 and had two key purposes: to develop tools to screen and identify learners who experience barriers to learning and development, and to establish a support package to address these barriers (DOE, 2008). According to the SIAS strategy, the class educator, who will be the first person to assess the learner, will refer the learner to the institutional-level support team. The educator, parents and institution-level support teams (ILST) will then decide if the learner needs support in the school or home intervention. A formal assessment to determine the level of support and the type of support package needed will then done by the DBST. At this stage, professionals, including therapists who are needed to provide support, must give their input in terms of more formal assessments (DOE, 2008).

The implementation of the SIAS is currently in its piloting phase and the question needs to be raised as to what the changes will be, if a different strategy for assessment of learners (SIAS) is to be implemented.

5.2.1.3 Intervention, management and treatment

In this study, most occupational therapists reported that they assessed and provided support to developing skills of learners with motor, intellectual and learning disabilities; most physiotherapists reported that they assessed and provided support to develop skills of learners with motor impairments; and most speech and language therapists reported that they assessed and provided support to develop skills of learners with hearing, speech and language impairments.

In this study, therapists (OT: 39%; PT: 28%; SLT: 4%) claimed to be involved in developing health-maintenance skills. In comparison to Struthers' (2005b) findings (OT: 25%; PT: 27%; SLT: 10%), the results indicate an increase of 14% of occupational therapists who became involved with health maintenance.

In comparison to Struthers' (2005b) conclusions, the results indicate that fewer speech and language therapists were involved in developing the learners' skills related to activities of daily living. The following activities were reduced, namely, oral hygiene (34% fewer), personal device care (13% fewer) and feeding and eating activities (28% fewer).

In this study, therapists (OT: 9%; PT: 48%; SLT: 0%) said they were developing learners' skills to be mobile in the community. In comparison to Struthers' study (OT: 29%; PT: 21%; SLT: 10%), the results indicate a decrease of 20% of occupational therapists, an increase of 27% of physiotherapists and a decrease of 10% of speech and language therapists became involved in community mobility of learners. Community mobility includes transport accessibility and being independently mobile in the community. This increased involvement in community mobility may imply that physiotherapists had an increased awareness of the need to integrate learners into the community by teaching learners to use public transport independently.

According to Landrum, Schmidt, and McLean (1995), functional outcome levels for acute and rehabilitation services range from 0-5 (0-2 acute; 2-5 rehabilitation). The different levels for rehabilitation are physiological maintenance on level 2, residential reintegration on level 3, community reintegration on level 4 and productive activity on level 5. Occupational

therapists and physiotherapists assisted learners in developing skills to function independently at levels 3, 4 and 5. The results in this study and in that of Struthers (2005b) indicate that the majority of occupational therapists and physiotherapists were involved in developing the motor skills of learners with disabilities. Motor skills, especially gross motor skills to improve mobility, such as walking with assistive devices and wheelchair mobility, are developed to re-integrate learners at home and at the community (levels 3 and 4, according to Landrum et al., 1995).

In this study, the therapists (OT: 85%; PT: 96%; SLT: 8%) reported providing special seating positioning for learners with physical disabilities of learners. Compared to Struthers' (2005b) results (OT: 43%; PT: 88%; SLT: 10%), the results indicated an increase of 42% of occupational therapists who were involved in seating positioning of learners. This implies that more occupational therapists were developing a safe and supportive teaching and learning environment for learners, which forms part of the health-promoting schools framework.

Occupational therapists were still playing a role in work and productive activities (level 5, according to Landrum et al., 1995) and home management skills but were showing a reduction in all these activities. Fewer occupational therapists were involved with work and productive activities (work performance preparation: 15% fewer). Home management skills were developed by fewer occupational therapists (clothing care: 21% fewer; cleaning: 10% fewer; meal preparation: 15% fewer; shopping: 19% fewer; money management: 30% fewer). This implies that occupational therapists have reduced their direct support in developing work-performance preparation and home management skills. In spite of these findings, therapists reported that they were involved in developing skills of learners, which forms part of the health-promoting schools framework.

In this study, most occupational therapists and physiotherapists reported that they were involved in play and leisure activities. In this study, therapists (OT: 65%; PT: 60%; SLT: 24%) stated that they were involved in play exploration. In comparison to Struthers' (2005b) results (OT: 79%; PT: 73%; SLT: 24%), this indicates that a decrease of 14% of occupational therapists and a decrease of 13% of physiotherapists were involved in play exploration. In this study, therapists (OT: 4%; PT: 52%; SLT: 4%) said they were involved in the prevention of sports injuries. In comparison to Struthers' (2005b) findings (OT: 14%; PT: 73%; SLT: 0%), the results indicate a decrease of 10% of occupational therapists and a decrease of 21%

of physiotherapists preventing sports injuries. These findings indicate less involvement of therapists in play and leisure activities. In this study, therapists (OT: 13%; PT: 48%; SLT: 0%) indicated they were also involved in horse riding. In comparison with Struthers' (2005b) conclusions (OT: 11%; PT: 33%; SLT: 5%), the results indicate that 15% more physiotherapists were involved with horse riding. In this study, therapists (OT: 52%; PT: 88%; SLT: 28%) reported that they were involved with sports for disabled learners. In comparison to Struthers' (2005b) study (OT: 50%; PT: 73%; SLT: 33%), the results indicate that an increase of 15% of physiotherapists were involved with sports for disabled learners. These results indicate an increase of cultural activities by physiotherapists, showing that therapists were developing the psychosocial aspect of the environment, which is a component of the health-promoting schools framework. These are all cultural activities, indicating that therapists were developing a safe and supportive learning environment, which can be physical or psychosocial (DOE, 2005a). Cultural activities such as play, sports for learners with physical disabilities and horse riding indicate that therapists were involved in developing the psychosocial aspect of the environment, which forms part of the health-promoting schools framework. The reduction of some of these activities indicates that therapists have reduced their indirect support to the psychosocial environment.

Learners with disabilities voiced their concern, in a study done by Pivik, McComas, and Laflamme (2002), in Canada, that physical education facilities were inaccessible and that educators gave them substitute work as score keepers instead of adapting the curriculum and the facilities. According to McQueen and Mackey (1998), physical education for learners with disabilities has been viewed as therapy which must be done separately. This implies segregation, which does not support the principles of inclusive education.

Therapists in this study indicated that they provided their direct support to learners on an individual basis or in groups. Struthers (2005b) found that occupational therapists and speech and language therapists tended to work more often with learners in groups than individually and that physiotherapists worked with individual learners more often than with learners in groups. However, this study showed that the majority of speech and language therapists have changed to working more often with individual learners. This is more intensive work and might explain why speech and language therapists have “withdrawn” from other activities and focused more on developing individual learners' hearing, speech and communication skills.

In conclusion, the findings indicate that therapists still maintain their traditional roles, but there has been a reduction or non-involvement in some activities. Although occupational therapists still play a dominant role with developing home management skills, 30% fewer occupational therapists were involved in the money management activities. More occupational therapists (42% more) were doing special seating positioning for learners with disabilities. More physiotherapists (27%) were involved in community mobility. Fewer speech and language therapists were developing skills in activities of daily living, life skills, and skills in home management and motor function activities. These changes indicate a reduction in direct support, which may imply that therapists are in the process of changing their model of support. Although therapists reported that they were still using the medical model of support, fewer were using direct support than before. On the other hand, therapists were using the different strategies of the health-promoting schools framework by developing the skills of learners and developing a safe and supporting teaching and learning environment.

5.2.1.4 Evaluation of intervention, management and treatment

In this study, therapists (OT: 76%; PT: 84%; SLT: 76%) stated that they always evaluated their interventions. In comparison with Struthers' (2005b) report (OT: 68%; PT: 52%; SLT: 81%), the results indicate an increase of 32% of physiotherapists "always" evaluated their intervention. In this study, 76% of therapists (OT: 80%; PT: 80%; SLT: 68%) determined whether the goal of the intervention was achieved within the proposed timeframe. This was higher than in the study of Struthers (2005b), who found that 65% of therapists (OT: 57%; PT: 58%; SLT: 80%) determined whether the goal was achieved within the proposed timeframe.

The evaluation of an intervention is important to gain evidence of the effectiveness of the support and how the models of support were used. A number of studies have focused on the effect of school-based therapy that improves their school performance on the functional outcomes of learners with disabilities (Bayona, McDougal, Tucker, Nichols, & Mandich, 2006; Dreiling & Bundy, 2003; Dunn, 1990; King et al., 1999). King et al. (1999) found significant improvement in the functional status and individual goal attainment of learners receiving occupational therapy, physiotherapy and speech and language therapy. According to King et al. (1999), therapists need to become skilful researchers by participating in inquiry, and integrating this information into practice to enable them to support clinical practices and

outcomes with data-based evidence. Dreiling and Bundy (2003) compared the direct model of support with a direct-indirect intervention with preschoolers. The results of their study indicated that these models of support were equally effective to address goals to improve motor performance of preschoolers (Dreiling & Bundy, 2003). This information indicates that using only direct support has the same functional outcome as using a combination of the direct and indirect support. This may imply that therapists need to balance their support provision with more indirect support, rather than using only direct support, which is more costly and for which more therapists are needed for one-to-one interventions (Levangie, 1980).

Depending on whether the interventions were applied directly to the learner or indirectly to the educator, parent, and the environment, the evaluation of interventions suggests that therapists were using both the medical and the health-promoting model of support.

5.2.1.5 Teamwork

Most therapists indicated that there was an occupational therapist, a physiotherapist, a speech and language therapist, psychologists, and a school nurse at their workplace, but only a minority of therapists indicated there was a social worker at their workplace. Comparing the results with those of Struthers (2005b) suggests that the number of posts of social workers had not been increased in special schools by the WCED over the past years. Therapists made decisions with other team members when identifying learners' support needs, the treatment goal and evaluation of the outcome of therapists' support.

The majority of therapists indicated that they always involved the learner and the educator when assessing the learner and identifying the support needs and treatment goals. Comparing the results with those of Struthers (2005b) suggests that there is no change.

When evaluating their outcome of support, the majority of therapists claimed they would always include the learner. In this study, therapists (OT: 69%; PT: 80%; SLT: 77%) reported that they included the learner when evaluating the outcome of support. In comparison to Struthers' (OT: 46%; PT: 79%; SLT: 81%) findings, the results indicate an increase of 23% occupational therapists who included the learner when evaluating the outcome of support. The majority of physiotherapists would sometimes include the educator when evaluating their outcome of support. In comparison to Struthers' (2005b) study, the results suggest no change. The majority of therapists would only sometimes include parents when they evaluated their

support to learners, which indicated that therapists did not always include the parents when evaluating the outcome of their support. In comparison to Struthers' (2005b) results, the results suggest no change.

According to the authors of the literature consulted, in the multidisciplinary team approach, therapists work in isolation without collaboration amongst them to make joint decisions regarding the implementation of recommendations, the application of teaching approaches or to determine the resources that are required (Lacey & Lomas, 1993; McQueen & Mackey, 1998; Rapport, 2002). Collaborative consultation (collaborative team approach) refers to an equal partnership among therapists, educators and other key role players to identify, plan and implement recommendations (Dunn, 1988; Hartas, 2004; Lacey & Lomas, 1993). Collaboration means joint planning, decision making and problem solving directed toward a common goal, which results in effectively meeting the diverse needs of learners and better protection of the rights of the child (Engelbrecht, 2006; Lacey & Lomas, 1993).

According to Jirikowic et al. (2001), the inclusion of the family is necessary to integrate functional skills of learners with disabilities into the home and community settings. In the USA, changes in special education law, under the Individuals with Disabilities Education Act (IDEA), mandates that therapists' support provision must be education related, in the least restrictive natural environments, and with the emphasis on family involvement (Jirikowic et al., 2001).

According to Struthers and Lewis (2004), partnerships need not only to be formed with other professionals but also with parents and even with the learner. Therapists form part of a team, which involves collaboration with other professions in order to co-ordinate assessment needs and treatment goals. In this study, therapists said they would more often include other therapists when evaluating the treatment than when doing the initial planning of the assessment.

In this study, the majority of therapists (OT: 56%; PT: 91%; SLT: 60%) indicated that they "always" involved therapists of their own profession when assessing support needs and treatment goals. In comparison to Struthers' (2005b) report (OT: 36%; PT: 48%; SLT: 43%), 20% more occupational therapists, 43% more physiotherapists, and 17% more speech and language therapists were "always" included by their own professions during the assessment procedure. In this study, the majority of therapists (OT: 53%; PT: 70%; SLT: 33%) stated that they "always" involved their own profession when evaluating treatment. In comparison

to Struthers' (2005b) findings (OT: 18%; PT: 21%; SLT: 24%), 35% more occupational therapists, 49% more physiotherapists and 11% more speech and language therapists were "always" included by their own professions when evaluating treatment. These results indicated that therapists have increased collaboration amongst their own profession.

In this study, the majority of occupational therapists maintained that they "always" included 64% of physiotherapists when assessing learners' needs. In comparison to Struthers' (2005b) claims, 70% of occupational therapists included physiotherapists, which suggests no change. In this study, the majority of occupational therapists said they "sometimes" included other therapists (PT: 65%; SLT: 63%) when evaluating the treatment. In comparison to Struthers' (2005b) study (PT: 45%; SLT: 48%), 20% more physiotherapists and 15% more speech and language therapists were included by occupational therapists when evaluating the treatment.

In this study, physiotherapists stated that they "sometimes" included other therapists (OT: 53%; SLT: 48%) when assessing learners' needs. In comparison to Struthers' (2005b) results (OT: 29%; SLT: 48%), 24% more occupational therapists were included by physiotherapists when assessing learners' needs. In this study, physiotherapists said they sometimes included other therapists (OT: 72%; SLT: 67%) when evaluating the treatment. In comparison to Struthers' (2005b) conclusions (OT: 39%; SLT: 42%), 33% more occupational therapists and 25% more speech and language therapists were "sometimes" included by physiotherapists when evaluating the treatment.

In this study, speech and language therapists claimed to "sometimes" include other therapists (OT: 53%; PT: 55%) when assessing learners' needs. In comparison to Struthers' (2005b) findings (OT: 39%; PT: 33%), 14% more occupational therapists and 22% more physiotherapists were included by speech and language therapists when assessing learners' needs. In this study, speech and language therapists stated that they "sometimes" included other therapists (OT: 68%; PT: 72%) when evaluating the treatment. In comparison to Struthers' (2005b) study (OT: 39%; PT: 45%), 29% more occupational therapists and 27% physiotherapists were "sometimes" included when evaluating treatment. These results indicated that therapists have improved their collaboration efforts with other therapists.

Therapists need skills, including teamwork skills, to collaborate with other professions, especially with educators (Giangreco, 1995; Struthers, 2005b; Wright & Kersner, 1998). One of the challenges that face South African therapists is to know how to work in the classroom

and maintain an equal partnership with educators as this is critical for successful collaboration (Struthers & Lewis, 2004).

The literature shows differences regarding areas of multidisciplinary collaboration. Kersner and Wright (1996) reported that collaboration is more likely to take place with the initial planning of assessment than with the intervention. On the other hand, Wright and Graham (1997) found that there was more collaboration involved with intervention than with assessment of learners. In this study, it was shown that more collaboration took place when the intervention was evaluated than with the initial planning of the assessment. However, Struthers (2005b) found that more collaboration occurred amongst therapists with the assessments of learners' needs than with the evaluation of the intervention.

These results suggest that therapists are in the process of changing their model of support by using more collaborative consultation than before.

5.2.1.6 Referral of learners to therapists outside school

Therapists in this study indicated that they referred learners for direct support to other therapists in state and private hospitals. According to Struthers (2005b), some therapists would refer severely disabled learners to therapists in private practice for treatment during the long holidays.

In this study, 60% of therapists (OT: 63%; PT: 56%; SLT: 60%) and in Struthers' study 64% of therapists (OT: 68%; PT: 61%; SLT: 62%) indicated that they referred learners to therapists outside the school for more direct support. When compared to Struthers' (2005b) study, the results suggest minimal change. Most therapists referred learners to their colleagues of the same profession in private practice rather than to the state sector. In this study (OT: 20%; PT: 40%; SLT: 20) and in Struthers' (2005b) study (OT: 18%; PT: 42%; SLT: 33%), therapists indicated that learners are given acceptable support by therapists in the special schools and that those families could not afford the costs of treatment elsewhere. In comparison to Struthers' (2005b) findings, the results suggest minimal change.

According to Swart and Pettipher (as cited by Engelbrecht, 2006), important characteristics of inclusive education are the effective use of existing resources and increasing additional resources, from within the school but also from the community in which the school is located. It is necessary for schools to form strong collaborative partnerships with the community in order to draw on these resources. According to the Education White Paper 6, a community-

based approach to support will enable all resources in the community to be used to develop and support education through collaboration with other sectors, including health and welfare (DOE, 2005a).

Therapists referring learners outside the special schools for more direct therapy strengthened the use of the medical model of support.

5.2.2 Indirect learner support

In the following section, the roles of therapists in using four of the five strategies of the health-promoting schools framework will be discussed. The fifth strategy, re-orientation of support services, was discussed in Section 5.2.

5.2.2.1 Therapists' role in developing healthy school policy

Developing healthy school policy is the first strategy of the health-promoting schools framework. Therapists should be involved with advocacy and attend meetings to influence policy.

The findings in this study and that of Struthers indicate that the minority of therapists were involved in advocacy with parents, educators and local campaigns to involve the community in inclusive education.

In this study, therapists (OT: 30%; PT: 24%; SLT: 16%) reported that they were collaborating with parents to accept children with disabilities from the special school into the ordinary schools. In comparison to Struthers' (2005b) report (OT: 32%; PT: 30%; SLT: 24%), the results suggest no change. In this study, therapists (OT: 11%; PT: 4%; SLT: 12%) indicated that they participated in local campaigns. When compared to Struthers' (2005b) findings (OT: 4%; PT: 9%; SLT: 0%), the results suggest that an increase of 12% of speech and language therapists have become involved in local campaigns.

Therapists in this study (OT: 35%; PT: 24%; SLT: 12%) also had to advocate with educators in ordinary schools to accept learners from the special school. In comparison to Struthers' (2005b) findings (OT: 36%; PT: 33%; SLT: 14%), the results suggest minimal change. This may imply that therapists do not have collaborating skills or that the minimum of therapists are providing their support to the ordinary schools. According to Struthers (2005b), advocacy is an important part of health promotion and needs collaboration between therapists, educators, parents and other community workers.

According to Jirikowic et al. (2001), therapists need to become advocates for learners with disabilities and their families and for services and systems that support a diverse range of individual needs. Therapists must learn to advocate for rights of learners with disabilities to remove legislation that limit therapeutic services to undesirable levels (Jirikowic et al., 2001). The Department of Education stated that district-based support teams need to become involved with advocacy of parents and communities on the rights within the inclusive education system (DOE, 2005a).

The results indicate that only a few therapists were involved in advocacy, which suggests that a few therapists used advocacy to influence policy regarding inclusive education and to develop a safe and supportive teaching environment, which forms part of the health-promoting schools framework.

The percentage of therapists' managerial duties remained the same for the two studies, namely, that most of the therapists were involved in administrative duties, influencing policy, meetings with educators and other therapists, as well as doing fundraising for the special school.

In this study, therapists (OT: 35%; PT: 28%; SLT: 32%) claimed they attended meetings with the EMDC. In comparison to Struthers' (2005b) report (OT: 54%; PT: 48%; SLT: 57%), 19% fewer occupational therapists, 20% fewer physiotherapists and 35% fewer speech and language therapists attended meetings at the EMDC. Therapists, as part of the district-based support team, are supposed to attend more meetings at the EMDC. These findings may imply that therapists were not involved in meetings and decision making at the district level.

In this study, only a small percentage of therapists (OT: 4%; PT: 12%; SLT: 4%) indicated being members of school governing bodies. In comparison to Struthers' (2005b) study (OT: 7%; PT: 6%; SLT: 5%), the results suggest no change. More therapists in this study (OT: 39%; PT: 36%; SLT: 44%) were members of the school committee. In comparison to Struthers' (2005b) report (OT: 43%; PT: 39%; SLT: 52%), the results suggest no change. A similar proportion of therapists in this study (OT: 44%; PT: 44%; SLT: 44%) and in Struthers' study (OT: 46%; PT: 36%; SLT: 43%) were in a position to influence policy. Therapists indicated that they do play a role in developing healthy school policy, which forms part of the health-promoting schools framework.

5.2.2.2 Therapists' role in developing a safe and supportive teaching and learning environment

Developing a safe and supportive teaching and learning environment is the second strategy of the health-promoting schools framework. Therapists gave an indication that they played a role in adapting the school's physical environment to enable learners to gain access to the curriculum, thus facilitating learning and development. Therapists adapted the physical environment by giving advice about ramps, rails, toilets and basins, the school classroom and the school playground.

In this study, therapists (OT: 39%; PT: 52%; SLT: 12%) maintained that they gave support to the school environment by adapting the classroom. In comparison to Struthers' (2005b) report (OT: 54%; PT: 48%; SLT: 10%), the results indicate a decrease of 15% of occupational therapists who adapted the classroom.

In this study, therapists (OT: 20%; PT: 28%; SLT: 4%) claimed they were adapting the playground. In comparison to Struthers' (2005b) conclusions (OT: 21%; PT: 39%; SLT: 0%), the results indicate a decrease of 11% of physiotherapists who adapted the playground. Although there is a decrease in adapting the physical environment, therapists were still providing their support in the health-promoting schools framework by developing a safe and supportive teaching and learning environment.

Most of the therapists in this study (OT: 72%; PT: 72%; SLT: 72%) indicated they were involved in fundraising activities for special schools. When compared to Struthers' (2005b) study (OT: 75%; PT: 73%; SLT: 76%), the results suggest no change. In this study (OT: 13%; PT: 60%; SLT: 20%), therapists said they were involved in fundraising activities for assistive devices. In comparison to Struthers' (2005b) study (OT: 21%; PT: 55%; SLT: 33%), 13% more speech and language therapists were involved in fundraising activities for assistive devices. Assistive devices are necessary to create a safe and supporting teaching and learning environment, which forms part of the health-promoting schools framework.

The DOE (2005a) also pointed out that barriers to learning relating to the physical and psychosocial environment within which teaching and learning occur can also include buildings as well as management styles (DOE, 2005a). According Lazarus et al., (1999), physical environmental barriers can occur in the form of inaccessibility in terms of the building structures, the classrooms and equipment. Therapists indicated that they were

developing a safe and supporting teaching and learning environment by adapting the physical school environment, which is a strategy of the health-promoting schools framework.

Therapists were developing a safe and supportive teaching environment by the provision of assistive devices. The provision of assistive devices helps learners to access the curriculum by removing barriers of learning (Struthers, 2005b). According to Struthers (2005b), assistive devices are important modifications that promote independence and increase learners' accessibility to the curriculum.

The majority of occupational therapists and physiotherapists said they provided the educators with equipment and special seating for learners. The majority of physiotherapists trained the educators about adapted standing positions and how to take care of mobility devices. In comparison to the findings of Struthers (2005b), the results indicate that 31% more physiotherapists provided educators with equipment than before, 32% fewer speech and language therapists provided equipment and 10% fewer speech and language therapists informed educators on the care of mobility devices.

Fewer occupational therapists (16% less) taught educators about special seating for learners with physical disabilities and 12% fewer occupational therapists taught educators adapted standing positions for learners with physical disabilities. The reduction in this activity may imply that there is a lack of resources available. Although the other therapists reduced these activities, physiotherapists became more involved in developing skills of educators, which forms part of the health-promoting schools framework.

According to Merbler, Hadadian, and Ulman (1999), the Individuals with Disabilities Education Act in the USA (IDEA, 1990) defines assistive technology as any device or item that can be used to increase, maintain or improve the capabilities of children with disabilities. Assistive technology can range from a large grip pencil to a sophisticated voice recognition computer system (Merbler et al., 1999). According to Dyal, Carpenter, and Wright (2009), assistive technology services and devices may allow the learner with disabilities access to the general education curriculum for academic, social and extracurricular activities.

Most therapists claimed to be involved in training non-teaching personnel, namely, classroom assistants, but the majority of physiotherapists (96%) were training bus drivers. Compared to Struthers' (2005b) results, 13% more physiotherapists became involved in the training of classroom assistants, 23% more physiotherapists trained bus drivers, 16% more

physiotherapists trained hostel personnel and 26% more physiotherapists trained administrative personnel. The implication is that therapists, especially physiotherapists, have become more alert to the need to teach non-teaching personnel kinetic handling and ergonomics. This also indicates that therapists have become more involved in developing a safe and supportive teaching and learning environment, which forms part of the health-promoting schools framework (DOH, 2000).

In this study, therapists (OT: 37%; PT: 76%; SLT: 4%) reported that they provided support to parents by doing adaptations of their homes. In comparison to Struthers' (2005b) study (OT: 36%; PT: 58%; SLT: 14%), the results indicate an increase of 18% of physiotherapists and a decrease of 10% of speech and language therapists who adapted parents' homes. More physiotherapists were involved in developing a safe and supportive environment at home by the adaptation of the parents' homes, which forms part of the health-promoting schools framework.

5.2.2.3 Therapists' role in building school-community networks and partnerships

Building school-community networks and partnerships is the third strategy of the health-promoting schools framework. Therapists claimed they connected with different non-governmental organisations and formed partnerships with parents.

In this study, the majority of therapists (OT: 84%; PT: 74%; SLT: 77%) indicated that they were developing their departments as resource centres. In comparison to Struthers' (2005b) study (OT: 82%; PT: 64%; SLT: 62%), the results suggest an increase of 10% more physiotherapists and 15% more speech and language therapists who were developing their departments as resource centres.

Therapists supported the community by providing information about disability and about organisations for people with disabilities. Training was also done in the form of open days, workshops and talks in the community.

In this study, therapists (OT: 38%; PT: 60%; SLT: 32%) claimed to be giving information to the community about organisations that provide assistance. In comparison to Struthers' (2005b) findings (OT: 46%; PT: 33%; SLT: 24%), the results indicate 27% more physiotherapists were giving information about organisations that provide assistance.

In this study, therapists (OT: 20%; PT: 32%; SLT: 8%) reported providing information to the community regarding the rights of children with disabilities. In comparison to Struthers' (2005b) findings (OT: 29; PT: 21%; SLT: 5%), these results indicate an increase of 11% of physiotherapists who gave information about the rights of children with disabilities.

In this study, the majority of physiotherapists were linked to community organisations such as St Giles (PT: 52%) and the CP association (PT: 64%). In comparison to Struthers' (2005b) findings, St Giles (PT: 48%) and the CP association (PT: 67%), these results suggest no change. In this study, a few therapists (OT: 14%; PT: 8%; SLT: 28) said they were also involved with Interface. In comparison to Struthers' (2005b) study (OT: 21%; PT: 6%; SLT: 57%), the results indicate fewer speech and language therapists (29% less) were involved with Interface.

In this study, therapists (OT: 41%; PT: 20%; SLT: 4%) said they were in contact with the Western Cape Forum for Intellectual Disability. In comparison to Struthers' (2005b) study (OT: 21%; PT: 21%; SLT: 0%), the results indicate an increase of 20% of occupational therapists who made contact with the Western Cape Forum for Intellectual Disability. In this study, therapists (OT: 39%; PT: 8%; SLT: 24%) stated they had contact with the Western Cape Forum for Inclusive Education. In comparison to Struthers' (2005b) study (OT: 21%; PT: 3%; SLT: 0%), the results indicate an increase of 18% of occupational therapists and an increase of 24% of speech and language therapists who made contact with the Western Cape Forum for Inclusive Education. This may imply that occupational therapists and speech and language therapists have become more involved with organisations supporting inclusive education.

In this study, therapists (OT: 22%; PT: 36%; SLT: 12%) reported attending meetings with the non-governmental body. In comparison to Struthers' (2005b) findings (OT: 29%; PT: 18%; SLT: 0%), physiotherapists have increased (18% more) and speech and language therapists have increased (12% more) their meetings with the non-governmental bodies. Meetings are necessary to collaborate with other team members in the school community. These findings imply that more therapists are forming partnerships with the non-governmental organisations in the community.

Therapists provided their support indirectly to the learner by providing information to parents, developing parents' skills, and assisting parents in their homes. In this study, more than 50% of physiotherapists and occupational therapists (Struthers, 2005b: 43%) reported

that they did home visits and 76% of physiotherapists (Struthers, 2005b: 58%) helped with home adaptations. This indicates that therapists are moving to a certain extent towards a more holistic approach, operating in a health-promoting support system by building school community networks and partnerships, especially with parents (DOH, 2000). However, therapists could strengthen these partnerships by connecting parents with organisations for people with disabilities and giving parents information on the rights of people with disabilities.

In summary, therapists showed they were playing a role in building school-community networks and partnerships, which forms part of the health-promoting schools framework.

5.2.2.4 Therapists' roles in developing skills

Developing the personal skills of all in the school community is the fourth strategy of the health-promoting schools framework. Therapists claimed they were developing the skills of learners (Section 5.2.1.3), educators, learners in ordinary schools and parents. Therapists were also developing their own capacity and the capacity of students.

a) Support to educators

The Department of Education stated that special schools must become resource centres and, with their specialised staff, should support the educators at the ordinary schools (DOE, 2005b). Prinsloo (2001) reported that a disturbing number of educators in South Africa are confused and insecure, because of a series of radical changes which have transformed their work environment. This requires the training of educators to think and work in a new frame of reference. A survey done by Lessing and De Witt (2008), shows that educators do not know enough about barriers contributing to learning difficulties, and that they are not confident enough to support learners and facilitate the removal of these barriers. Therapists also need to understand their own roles regarding support provision in order to support educators in the process of implementing inclusive education.

This results of this study indicated that therapists were more focused on working in the special schools than on providing their support to ordinary schools. In special schools, the majority of therapists often gave individual support to educators and only sometimes gave support to educators in groups. In ordinary schools, very few therapists gave individual or group support to educators or institutional-level support teams. The majority of therapists indicated that they never gave individual or group support to the educators at the EMDC and

to institutional-level support teams. In comparison to Struthers' (2005b) findings, the results suggest there has been no change in the support provided to educators at the ordinary schools.

The majority of occupational therapists were supporting the educators through the curriculum and through teaching educators behaviour management strategies. In comparison to Struthers (2005b), the results indicate that 32% more occupational therapists increased their support to the curriculum by adapting the content (21% more), developing alternate ways to present the curriculum (19% more) and evaluating the learners (21% more). The majority of speech and language therapists supported the educators with language development and alternative augmentative communication, and 21% decreased their support regarding curriculum adaptation, but 20% more were involved in the adaptation of the curricular content and the majority of speech and language therapists were still involved in language development. The majority of occupational therapists and physiotherapists adapted physical activity for the educators, a conclusion which is similar to the findings of Struthers (2005b). These findings confirm that therapists have increased their indirect support to educators by making the curriculum more accessible to learners. Therapists were playing a role in developing personal skills of learners (the fourth component of the health-promoting schools framework) by assisting educators in reducing barriers to learning.

In this study, the majority of therapists (OT: 83%; PT: 96%; SLT: 64%) stated that they provided educators with information about learners' disabilities. In comparison to Struthers' (2005b) study (OT: 93%; PT: 100%; SLT: 90%), there has been a decrease of 10% of occupational therapists and a decrease of 26% of speech and language therapists who provided educators with information about learners' disabilities. The majority of physiotherapists provided educators with information about the learners' surgery. This is similar to the findings of Struthers (2005b).

In this study, therapists (OT: 30%; PT: 60%; SLT: 20%) claimed they provided educators with information about organisations for people with disabilities. In comparison to Struthers' (2005b) report (OT: 57%; PT: 55%; SLT: 14%), there has been a decrease of 27% of occupational therapists who provided educators with information about organisations for people with disabilities. In this study, a few therapists (OT: 24%; PT: 24%; SLT: 8%) said they provided information to educators on the rights of people with disability. In comparison to Struthers' (2005b) findings (OT: 36%; PT: 21%; SLT: 5%), there has been a decrease of 12% of occupational therapists who provided information to educators on the rights of people

with disability. This may imply that therapists were not well informed about organisations for people with disabilities and the rights of people with disabilities, or that the need to provide this information to educators was not a priority. This change implies that fewer occupational therapists are connecting educators with organisations for people with disabilities.

b) *Support to learners in ordinary schools*

Therapists can support learners in ordinary schools by providing information about disability, about the rights of people with disabilities, about inclusion, and allowing learners from the ordinary school to visit the therapy department at the special school.

In this study, therapists (OT: 54%; PT: 50%; SLT: 48%) reported giving support to learners in ordinary schools by providing information on disability. In comparison to Struthers' (2005b) study (OT: 32%; PT: 52%; SLT: 48%), the results indicate an increase of 22% of occupational therapists who are providing support to learners in ordinary schools by giving information about disability.

In this study, therapists (OT: 30%; PT: 33%; SLT: 32%) claimed they were giving information to learners in ordinary schools about inclusion. In comparison to Struthers' (2005b) study (OT: 32%; PT: 15%; SLT: 0%), 33% more speech and language therapists and 18% more physiotherapists provided information about inclusion to learners in the ordinary school.

In this study, therapists (OT: 48%; PT: 40%; SLT: 50%) reported that they allowed learners from ordinary schools to visit their therapy department. In comparison to Struthers' (2005b) report (OT: 43%; PT: 52%; SLT: 38%), 12% fewer physiotherapists and 12% more speech and language therapists have been allowing learners of ordinary schools to visit the therapy department. This implies that more therapists, especially occupational therapists and speech and language therapists, are giving support to learners in the ordinary schools than before. Therapists are thus developing the personal skills of all in the school community by including learners in the ordinary school, which is one strategy of the health-promoting schools framework (DOH, 2000).

c) *Support to parents*

Therapists who took part in this study claimed they had more contact with parents of learners in the special school than with those in the ordinary school. In comparison to Struthers'

(2005b) findings, the results indicate that occupational therapists' support to parents stayed the same, but more physiotherapists became involved with providing home programmes to parents (10% more), helping with home adaptations (18% more) and liaising with the doctor on behalf of the learner (11% more).

In this study, the majority of occupational therapists and physiotherapists (OT: 52%; PT: 52%; SLT: 16%) maintained they supported parents by doing home visits. In comparison to Struthers' (2005b) study (OT: 43%; PT: 45%; SLT: 5%), the results indicate an increase of 11% of speech and language therapists who did more home visits. In this study, the majority of physiotherapists (OT: 61%; PT: 92%; SLT: 44%) said they supported parents by providing home programmes. In comparison to Struthers' (2005b) findings (OT: 64%; PT: 82%; SLT: 71%), the results indicate an increase of 10% of physiotherapists and a decrease of 27% of speech and language therapists who provided home programmes to parents. Providing home programmes to parents implies that therapists are developing the skills of parents, which forms part of the health-promoting schools framework.

In this study, therapists (OT: 28%; PT: 84%; SLT: 8%) reported that they liaised with doctors on behalf of the parents. In comparison to Struthers' (2005b) report (OT: 21%; PT: 73%; SLT: 33%), the results indicate an increase of 11% of physiotherapists and a decrease of 25% of speech and language therapists who liaised with doctors on behalf of parents. In this study, therapists (OT: 15%; PT: 68%; SLT: 8%) said they transported learners to hospital appointments. In comparison to Struthers' (2005b) study (OT: 18%; PT: 67%; SLT: 14%), these results suggest no change. Therapists were taking the responsibility of parents by transporting learners to hospital appointments. Although therapists were in a better position (as experts) to liaise with doctors on behalf of parents, they did not empower parents to take responsibility for their children.

The majority of occupational therapists (OT: 61%; PT: 28%; SLT: 36%) taking part in this study claimed they were teaching the parents behaviour management strategies. In comparison to Struthers' (2005b) study (OT: 75%; PT: 33%; SLT: 43%), the results indicate a decrease of 14% of occupational therapists who taught parents behaviour management strategies. In this study, the majority of speech and language therapists (OT: 11%; PT: 4%; SLT: 92%) stated that they taught parents about language development. In comparison to Struthers' (2005b) results (OT: 11%; PT: 12%; SLT: 95%), these results suggest no change.

In this study, therapists (OT: 17%; PT: 36%; SLT: 32%) reported they were teaching parents feeding techniques. In comparison to Struthers' (2005b) report (OT: 36%; PT: 33%; SLT: 43%), the results indicate a decrease of 19% of occupational therapists and a decrease of 11% of speech and language therapists who teach parents feeding techniques.

In this study, therapists (OT: 2%; PT: 0%; SLT: 36%) claimed to be teaching parents about hearing aids and FM maintenance. In comparing these claims to Struthers' (2005b) claims (OT: 0%; PT: 33%; SLT: 48%), the results indicate a decrease of 33% of physiotherapists and a decrease of 12% of speech and language therapists who teach parents about hearing aids and FM maintenance. These results may imply that physiotherapists were previously involved in this activity because of the unavailability of speech and language therapists. These results also indicate that therapists have reduced activities that develop parents' skills. According to the health-promoting schools framework, therapists need to develop the personal skills of all in the school community, including the parents.

In this study, the majority of physiotherapists (OT: 22%; PT: 88%; SLT: 0%) said they taught parents how to care for mobility assistive devices. In comparison to the results of Struthers' (2005b) study (OT: 21%; PT: 70%; SLT: 14%), these results indicate an increase of 18% of physiotherapists and a decrease of 14% of speech and language therapists who teach parents about caring for mobility assistive devices. In this study, therapists (OT: 44%; PT: 92%; SLT: 0%) claimed they taught parents about special seating and standing positions. In comparison to Struthers' (2005b) results (OT: 61%; PT: 97%; SLT: 19%), the results indicate a decrease of 17% of occupational therapists and a decrease of 19% of speech and language therapists who teach parents about special seating and standing positions. More physiotherapists and fewer speech and language therapists are thus involved in developing a safe and supportive environment and developing the skills of parents regarding special seating and standing positions, which are two components of the health-promoting schools framework.

In this study, therapists (OT: 33%; PT: 68%; SLT: 12%) reported that they involved parents in choosing assistive devices. In comparison to Struthers' (2005b) report (OT: 32%; PT: 70%; SLT: 43%), the results indicate a decrease of 31% percentage of speech and language therapists who involved parents in choosing assistive devices. This may imply that speech and language therapists have defined their role more clearly by concentrating on teaching parents on language development and augmentative communication and left the teaching of parents about other assistive devices to the occupational therapists and physiotherapists.

Therapists are thus empowering the parents by developing their skills in choosing the correct assistive devices, which forms a part of the health-promoting schools framework.

This study showed that therapists play an important role in developing parents' and educators' skills, which is another aspect of the health-promoting schools framework (Struthers, 2005b). According to Moletsane (2004), a lack of parental interaction with children can affect children's development negatively, but a positive, stable and supporting and stimulating relationship with parents can render children resilient to the negative effects of the environment. The development of parents' skills is important to ensure continuous support to the learner at home.

d) Capacity development of therapists

In this section, a discussion follows about capacity development of therapists, including the training, professional development, support and mentoring therapists are given.

Therapists have developed their capacity by attending courses organised by the WCED and the workplace therapists; short courses organised by specialised therapists, the professional association and the university; and, some, by obtaining a post-graduate degree.

The majority of therapists in this study (OT: 56%; PT: 84%; SLT: 68%) developed their capacity by in-service training organised by the workplace. In comparison to Struthers' (2005b) findings (OT: 54%; PT: 76%; SLT: 76%), the results suggest no change. The majority of therapists in this study (OT: 87%; PT: 96%; SLT: 72%) attended short courses done by specialist therapists. In comparison to Struthers' (2005b) reported results (OT: 71%; PT: 85%; SLT: 90%), the results indicate an increase of 16% of occupational therapists, 11% of physiotherapists and 18% of speech and language therapists who attended short courses run by specialist therapists.

In this study, therapists (OT: 58%; PT: 64%; SLT: 60%) reported that they developed their capacity through in-service training organised by the WCED. In comparison to Struthers' (2005b) results (OT: 39%; PT: 42%; SLT: 43%), the results indicate an increase of 19% of occupational therapists, an increase of 22% of physiotherapists and an increase of 17% of speech and language therapists who attended in-service training organised by the WCED. Struthers and Lewis (2004) advocated that in order to develop the capacity of therapists, they need to be included in in-service and pre-service training, which is structured in an interdisciplinary and intersectoral manner. This involves the joint training of therapists and

educators, and the inclusion of the community groups and departments of the health and welfare (Struthers & Lewis, 2004).

In this study, therapists (OT: 67%; PT: 88%; SLT: 52%) claimed to have attended short courses provided by their professional associations. In comparison to Struthers' (2005b) reported results (OT: 36%; PT: 33%; SLT: 24%), the results indicate an increase of 31% of occupational therapists, an increase of 55% of physiotherapists and an increase of 24% of speech and language therapists who developed their capacity by short courses provided by their professional associations.

In this study, therapists (OT: 22%; PT: 44%; SLT: 20%) said they developed their capacity by attending short courses given by the university. In comparison to Struthers' (2005b) findings (OT: 25%; PT: 27%; SLT: 19%), the results indicate an increase of 17% of physiotherapists who attended short courses at the university.

Post-graduate studies were reportedly done by therapists who took part in this study (OT: 2%; PT: 12%; SLT: 16%). In comparison to Struthers' (2005b) results (OT: 4%; PT: 3%; SLT: 29%), the results indicate an increase of 9% of physiotherapists and a decrease of 13% of speech and language therapists doing a post-graduate degree.

In this study, the minority of therapists (OT: 9%; PT: 0%; SLT: 4%) indicated that they had no formal training in the previous year. In comparison to Struthers' (2005b) findings (OT: 11%; PT: 3%; SLT: 0%), the results suggest no change. However, the increasing percentages indicated that more therapists are developing their own capacity to ensure continuous professional development.

One of the goals of Education White Paper 6 (2001) is the building of capacity and competencies of those providing education and other support services. Since the key to reducing barriers to learning is to strengthen education support services, the Department of Education commits itself to orientating and training education support personnel in their new roles of providing support to all educators (DOE, 2005a).

Mentoring is the practice of assigning a junior member of staff to the care of a more experienced person who assists him (or her) in his (or her) career (Collins Concise Dictionary, 2004). In this study, most therapists (OT: 78%; PT: 88%; SLT: 84%) stated that they were mentored by colleagues in the same profession. In comparison to Struthers' (2005b) study (OT: 75%; PT: 82%; SLT: 86%), the results indicate no change. In this study,

most therapists (OT: 71%; PT: 72%; SLT: 56%) reported receiving mentoring from colleagues from other therapy professions. In comparison to Struthers' (2005b) figures (OT: 75%; PT: 91%; SLT: 81%), the results indicate a decrease of 19% of physiotherapists and a decrease of 25% of speech and language therapists who received mentoring from other colleagues.

In this study, therapists (OT: 42%; PT: 56%; SLT: 44%) indicated that they received mentoring from the head of the department. In comparison to Struthers' (2005b) findings (OT: 25%; PT: 45%; SLT: 57%), the results indicate an increase of 17% of occupational therapists, an increase of 11% of physiotherapists, but a reduction of 13% of speech and language therapists who received mentoring support by the head of department. In this study, therapists (OT: 40%; PT: 28%; SLT: 32%) said they were also mentored by educators. In comparison to Struthers' (2005b) reported figures (OT: 43%; PT: 39%; SLT: 62%), 11% fewer physiotherapists and 30% fewer speech and language therapists received mentoring from the educators.

In this study, therapists (OT: 44%; PT: 28%; SLT: 12%) stated that they were also mentored by their principals. When compared to Struthers' (2005b) findings (OT: 29%; PT: 30%; SLT: 19%), the results indicate an increase of 15% of occupational therapists who received mentoring support from the principal. Therapists at the special school need the support of the principal to deliver their support to other schools. Engelbrecht, Oswald, and Forlin (2006) stated that visionary and devoted school leaders, who support inclusive and democratic values and principles, are necessary for schools to move towards a more inclusive and democratic system. If the principals do not support projects about inclusion, therapists cannot provide their support to other schools.

According to Rapport (2002), entry-level physiotherapists need additional training or mentorship from an experienced colleague because of the limited preparation at tertiary level for employment in a school-based setting. Jirikovic et al. (2001, p. 56) stated that mentoring relationships not only increase the therapists' education on an individual basis but also ensures the professions' continued development as "therapists learn from the past and together actively construct the future". In this study, therapists indicated that they received mentoring or support from colleagues of the same profession and other therapy professions, the head of department, educators and the principal.

These results indicate that therapists have increased their own capacity development, which showed that therapists are using one of the strategies of the health-promoting school, namely, to develop their own personal skills within the education context.

e) Capacity development of others by the therapists

Analysis of the literature indicates that tertiary institutions do not prepare therapists adequately at undergraduate-level studies to work in education settings because of the focus on the medical model and because paediatrics is seen as a specialised field (Effgen, 1994; Rapport, 2002; Struthers, 2005b). Therapists indicated that they developed the capacity of students, especially therapy students in the special schools and, to a much lesser extent, in the ordinary schools.

Therapists said they were involved in the capacity development of student therapists, medical and nursing students, and student educators.

In this study, therapists (OT: 48%; PT: 64%; SLT: 60%) claimed they were involved with the training of student educators. In comparison to Struthers' (2005b) figures (OT: 46%; PT: 58%; SLT: 62%), the results suggest no change. In this study, the majority of therapists (OT: 62%; PT: 80%; SLT: 60%) reported that they were involved in the training of student therapists in the special schools. In comparison to Struthers' (2005b) study (OT: 71%; PT: 67%; SLT: 76%), the results indicate an increase of 13% of physiotherapists and a decrease of 16% of speech and language therapists who are involved in the training of student therapists in the special schools.

Therapists also said that they allowed medical and nursing students to observe their work. In this study, therapists (OT: 13%; PT: 32%; SLT: 12%) indicated they were involved with the training of medical students. In comparison to Struthers' (2005b) report (OT: 29%; PT: 42%; SLT: 33%), the results indicate a decrease of 16% of occupational therapists, a decrease of 10% of physiotherapists and a decrease of 21% of speech and language who allow medical students to observe their work.

In this study, therapists (OT: 11%; PT: 36%; SLT: 0%) also claimed to be involved in the training of nursing students. In comparison to Struthers' (2005b) figures (OT: 14%; PT: 21%; SLT: 19%), the results indicate an increase of 15% of physiotherapists and a decrease of 19% of speech and language therapists (19% less) who are involved in the training of nursing students.

In this study, therapists (OT: 2%; PT: 8%; SLT: 8%) were shown to be involved in the teaching and training of student therapists in ordinary schools. In comparison to Struthers' (2005b) study (OT: 14%; PT: 6%; SLT: 0%), the results indicate a decrease of 12% of occupational therapists and an increase of 8% of speech and language therapists in training of therapists in ordinary schools. This gives another indication that therapists' support in ordinary schools is not yet established to facilitate student therapists at these schools. Although the results indicate a reduction of capacity development of others, there is an increase of 15% of physiotherapists who developed the capacity of nursing students and an increase of 13% of physiotherapists who developed the capacity of student therapists. Therapists were thus shown to develop the skills of others, which is one component of the health-promoting schools framework.

5.2.3 Overlapping of roles

In this section, the overlap of roles is discussed, using, as examples, activities cited by at least 30% of the sample. Although overlapping of roles occurred, therapists had their own unique roles. The occupational therapists were involved in work and productive activities, in health maintenance, and in providing assistive devices for writing, dressing and feeding. Occupational therapists and physiotherapists focused on developing motor function skills. Physiotherapists focused on developing community mobility skills and on play and leisure activities, such as prevention and treatment of sports injuries, and also provided mobility assistive devices, namely, walking aids and wheelchairs. Speech and language therapists focused on hearing, speech and communication skills and providing aids for communication.

This study shows a decrease in overlapping of roles, namely, physiotherapists not teaching parents alternate augmentative skills and speech and language therapists withdrawing from activities of daily living and not teaching parents about assistive devices. Occupational and speech and language therapists reduced their activity in teaching parents feeding techniques. An overall reduction in direct support is apparent, indicating that therapists are in the process of considering a more health-promotive model of support.

5.2.4 Summary of Section A

In Section A, the findings presented in the previous chapter to address Objective 1, which was to determine the model of support that therapists are using, were discussed. These findings indicate that most therapists use the medical model of one-to-one direct support and,

to a lesser extent, the health-promoting support model of indirect support. Therapists still mainly use direct therapy but have a more holistic approach, applying the five key elements of the health-promoting schools framework. The findings indicated that therapists were involved in developing healthy school policy, developing a safe and supportive teaching and learning environment, building school-community networks and partnerships, playing a role in developing personal skills of all in the community, and considering re-orientation of their support services.

In the following section, a discussion is presented to answer Objectives 2 and 3.

5.3 SECTION B: BARRIERS AND FACILITATORS TO EFFECTIVE SUPPORT

In this section, the results related to Objectives 2 and 3 will be discussed. Objective 2 was to determine the barriers that prevent therapists from providing their support in an inclusive education system. Objective 3 was to determine the facilitators that support therapists when they provide their support in an inclusive education system.

The barriers and facilitators that therapists had experienced emerged, in this study, in the themes that included the therapists' roles, intrinsic and extrinsic factors related to therapists, barriers and facilitators related to the district-based support teams and to the principals, therapists' relationships with the educators at the special schools and ordinary schools, and therapists' relationships with the parents.

5.4 BARRIERS TO EFFECTIVE SUPPORT

Barriers to therapists' support provision were related to the therapists' roles, barriers causing negative emotions, barriers related to the district-based support team and the principals, relationships with the educators at the full service school, and relationships with the parents.

5.4.1 Therapists' roles

The barriers that emerged from this study, related to the roles of therapists, were the lack of networking, therapists being unclear about their roles, their lack of knowledge and their inability to adapt the curriculum.

Some therapists indicated that one of their roles was to network with the school community, while other therapists expressed their disappointment at not being involved with the

community. Networking involves contacting and communicating with the school community, for example, the key role players at the other special schools, ordinary schools and full service schools.

Networking enables therapists, as part of the resource centres, to share their knowledge and skills with educators at other schools (DOE, 2005b). Networking also keeps therapists informed about the facilities available in the local community, and in the communities learners come from and allows them to advise on how to appropriately place learners with disabilities at the ordinary and full service schools. Furthermore, networking and advertising the services of the special schools allow the community to be informed about the services available as the special schools evolve into special school/resource centres. *If therapists do not inform the community of what is available at their school, this creates a barrier to therapeutic support provision to ordinary and full service schools*, because people will not use the facilities if they are not informed of what the school has to offer.

Networking allows the therapists and others in the special school to draw from the resources in the community by forming partnerships with different sectors in the community, not only the schooling community but also health and welfare sectors, non-governmental organisations, parents and voluntary workers (DOE, 2005a). Engelbrecht (2006) stated that if a school is not in a strong collaborative partnership with the community, it is difficult for it to draw from the resources in the community.

Some therapists indicated that they were unclear about their roles when providing support to ordinary schools. Therapists were uncertain whether they should give indirect support (consult with educators at other schools) or direct support (one-on-one therapy) and what setting to do it in. This uncertainty can be ascribed to the lack of skills and the lack of appropriate guidance. In this instance, therapists were not given guidance by the education district because positions had been vacated by key role players. These positions were never filled so no one was available to resume the responsibility of providing guidance to therapists regarding inclusive education. *The uncertainty about their roles resulted in a lack of confidence and created a barrier to therapists' support provision to the ordinary and full service schools.*

The Department of Education (2005a) stated that one of the key challenges for the development of district-based support teams is the capacity development of all support

service providers, to provide a holistic and comprehensive support service, which involves co-ordination and collaborative relationships (See Section 5.4.4).

Therapists also indicated that they lack knowledge and the ability to adapt the curriculum. Struthers and Lewis (2004) reported that only some therapists understand their role within the curriculum clearly and can confidently apply their skills and knowledge to work within the curriculum. This is because therapists are not usually included in pre-service and in-service training provided by the education department (Struthers & Lewis, 2004). *If therapists do not familiarise themselves with the curriculum and its outcome levels related to each learner's needs, and if they are uncertain about their roles at the ordinary schools, it creates a barrier to efficient support provision to educators in all schools.*

5.4.2 Barriers related to intrinsic factors

Barriers related to intrinsic factors refer to those factors that therapists experienced within themselves, namely negative emotions and the lack of specific skills, which prevented them from providing their support to ordinary schools.

5.4.2.1 Therapists' negative emotions

Therapists who participated in this study indicated that they experienced negative emotions such as frustration, feelings of powerlessness and feelings of guilt in their efforts to provide support to the schools.

Therapists' frustrations were caused by the district-based support team's failure to provide proper guidance and training to facilitate support provision. One particular source of frustration was the district-based support team which did not respond on time when the therapists at one special school requested a full service school to work with. However, these therapists alleviated their frustrations in this regard by choosing an ordinary school (a farm school) to provide their support to.

The district-based support team were also criticised for neglecting their duty to provide appropriate training for the therapists and guidance regarding inclusive education. Therapists felt frustrated when they did not know what their roles in the provision of support to the other schools involved. The fact that tertiary institutions focus on training in the medical model also does not contribute favourably to therapists' confidence to act as consultants (Struthers & Lewis, 2004). Therapists' lack of specific skills, identified in this study, caused frustrations

and they expressed the need for more training, especially to obtain skills to hold workshops for educators, to advance their skills in their specialised fields and to become better consultants. *The lack of skills to perform as consultants acted as a barrier to therapists' support provision.*

Other frustrations were caused by educators' different expectations of the service therapists could provide and educators not listening to the therapists' advice. Therapists were particularly frustrated when educators expected them to provide direct support instead of indirect support. Jirikowic et al. (2001) reported that one of the challenges that occupational therapists and physiotherapists in educational settings have to face is the inconsistent expectations of educators regarding therapists' responsibilities. Graham (as cited by Wright & Graham, 1997) reported that therapists and educators indicated that they acquire more realistic expectations of one another when they are working together. Engelbrecht et al. (2001) suggested that supporting roles need to move away from individualism and isolation to collaborative relationships, which involve direct interaction among co-equal partners, who voluntarily participate in joint decision making, sharing the responsibilities and accountability for the outcomes of the interaction. Struthers and Lewis (2004) stated that therapists need support from management, the educators, the parents, other therapists and even learners as the roles of therapists are changing from a medical model of direct support to a health-promoting model of indirect support. However, educators' different expectations relating to the learners mainly getting direct support formed a barrier to therapists' support provision.

Therapists indicated that their frustration was partly due to educators' unwillingness to listen to them and follow their advice. The educators interpreted therapists' guidance as indicating the educators were incompetent in the classroom. Engelbrecht et al., (2001) stated that educators, interviewed during their study, felt stressed by threats to their perceived professional competence with new administrative requirements and with the inclusion of learners with disabilities in their classes. Poor communication between therapists and educators may have caused this misinterpretation and resulted in the power struggle, acting as a barrier to therapists' support provision. *Therapists reported that when educators did not provide their co-operation, educators acted as barriers and therapists were unable to provide their support to them.*

Some therapists indicated that the lack of policy at the school level was one of the major causes of their frustrations. These therapists said that their principal was using technical excuses to prevent them from providing their support to ordinary schools. The principal wanted a policy as a “backup” if anything went wrong while therapists were in the community. Since no such policies were in place at the school, therapists were not allowed to go out to the community. School policy is developed within the school. This prompts the question: If the principal felt that a policy was necessary, why did she not develop one?

According to Struthers (2005b), once the Education White Paper 2001 had been issued, the inclusive education policy then needed to be implemented, not only at national level, but also at provincial, district and school level. One of the five strategies of the health-promoting schools framework is to develop healthy school policy that supports and promotes well-being (DOH, 2000). According to Struthers (2005b), therapists can influence and develop healthy school policies by participating on school governing bodies. Examples of healthy school policies include developing a safe and accessible environment inside and outside the school and inclusion of learners with disabilities in sports, leisure and cultural activities (Struthers, 2005b). A healthy school policy is also necessary to support therapists’ support provision to other schools.

Engelbrecht (2006) also found that one of the key concerns in schools was that there was no inclusive school philosophy that was shared with school communities and that there was a need for formal school policies. In spite of the national policy, the Education White Paper 6 (2001), the schools (in this study) had no policy in place that underlines inclusive education. *This lack of a school-based policy created conflict over activities at school level, which caused a barrier to therapists’ support provision.*

Therapists indicated that they experienced feelings of powerlessness as a result of autocratic leadership styles in the schools and because they did not form part of the district-based support team.

Some therapists reported that the problems or barriers they experienced that prevented them from giving support to other schools did not come from grassroots level but from officials in higher positions, namely, the principals and managers at district level. Therapists said that they have not been involved in decision making and that leadership styles are autocratic, which leaves them with a sense of powerlessness. Engelbrecht (2006) reported that one school community found it difficult to establish democratic leadership policies and practices

because the role of the principal was conservative and autocratic. According to Engelbrecht (2006), the implementation of inclusive measures would be more welcome at a school where the principal has a more democratic and inclusionary leadership style. *It can therefore be concluded that autocratic leadership styles of principals and district managers form a barrier to therapists' support provision.*

Therapists indicated that their feelings of powerlessness also came from being excluded from the district-based support team. The Department of Education (2005a) stated that therapists, as part of the resource centres (special schools), should form part of the district-based support team. These special school resource centres are supposed to collaborate with district-based support teams to provide support to full service and ordinary schools. A collaboration relationship speaks of an equal partnership, interaction with one another, joint decision making and sharing the responsibilities of recommendations and outcomes (Barnes & Turner, 2001; Engelbrecht, 2006; Hartas, 2004). *Therapists indicated that being excluded from the district-based support team and joint decision making left them with feelings of powerlessness, which acted as a barrier to support provision.*

Many therapists reported feelings of guilt when they have to go out of the special school to serve the community. They have the perception that because the WCED is paying their salary, their first priority should be with the learners at the special school. The therapists perceived it as an ethical problem to leave the school to go out into the community. Without realising it, the therapists were made to believe that their place was at the special school and not elsewhere. Therapists' limited perceptions of where they could work with learners and educators created feelings of guilt, causing a barrier to therapists' support provision to other schools.

Western Cape Education Department employees are now expected to provide their support to any school in the education district (DOE, 2005a). Therapists indicated that if they were based at the district and not at the school they would not feel guilty, but would then have the freedom to move around the district to provide their support to other schools. This demonstrates the restriction therapists experience at the special school where the principal uses an authoritative leadership style and does not employ inclusionary policies and practices (Engelbrecht, 2006; Forlin, 2004). *Therapists perceived being based at the special school as a barrier to their support provision.*

5.4.3 Barriers related to extrinsic factors

Therapists in this study indicated that they experienced barriers caused by extrinsic factors. These factors include a lack of human resources, which has an impact on therapists' prioritisation of time and determines the type of support provision to ordinary and full service schools and the costs of capacity development.

Therapists indicated that because of the lack of human resources, they need to act as consultants and that it would be difficult to provide their support to other schools, seeing that they could not meet the needs of all the learners at the special school. Time and the lack thereof have been indicated in the literature as a barrier to therapists' support provision (Chapman & Ware, 1999; Wright & Kersner, 1999; Jirikowic et al., 2001; Rapport, 2002). Educators and therapists being available at the same time, to collaborate, was also problematic (Barnes & Turner, 2001; Wright & Kersner, 2004; O'Toole & Kirkpatrick, 2007).

McCartney (2000) indicated that speech and language therapists need to prioritise which learners to see because of resource and staff limits. When learners with disabilities are together in the special school, it is easier to allocate speech and language therapy services, but the implication of inclusive education, where learners are geographically spread out into their immediate neighbouring schools, puts more demands on the therapists' service delivery. This has "forced" speech and language therapists in the UK to use parameters to prioritise learners who they feel can benefit the most from speech and language therapy services. These parameters include, amongst others, the severity of the problem, the permanency of the problem and the age of the learner in order to deal with the problem as early as possible (McCartney, 2000). *In summary, therapists indicated that a lack of time is a barrier.*

Therapists indicated that issues surrounding the costs of continuing training after qualifying left them unmotivated to continue their professional development. According to the therapists, the Western Cape Education Department does recognise post-graduate degrees with financial compensation for educators but does not recognise therapy-related courses that are not part of degrees. Therapists, therefore, are not financially subsidised for their courses, although they are using the skills and the knowledge obtained at these courses in their own school community. If therapists are not involved in continuous professional development, it influences the quality of support provision to the school community (special, ordinary and

full service schools). *Thus, the cost of financing their own training acted as a barrier to therapists' support provision to all schools.*

5.4.4 Barriers related to circuit boundaries

Therapists who responded to questions related to circuit boundaries in the study indicated that the circuit boundaries acted as a barrier when communication between the special school and the full service school was affected.

The education districts are each divided into circuits. The special school/resource centre and the full service school in one district were situated in different circuits and each circuit had its own manager, who did not communicate with the other. Circuit boundaries should not form a barrier since collaborative relationships must be formed with all key role players at all levels (DOE, 2005a). A relationship between the special school/resource centre and the full service school is important for therapists' support provision. Communication between the therapists from the special school/resource centre and the personnel of the full service school is essential for the exchange of knowledge and skills. *A barrier to therapists' support provision to the full service school is created when they are in different education circuits and the personnel from the two schools do not communicate easily with one another because of these circuit boundaries.*

5.4.5 Barriers related to principals

The principal's role as a barrier to therapists' support provision was reflected in the report of a case where the principal refused permission to allow therapists to start community projects. Therapists indicated that they regarded it as the inability of the principal to trust them and her fear that they would not succeed in the projects. Therapists felt that the principal was suppressing their professional growth, which was demoralising and left them despondent and discouraged. They said that therapists eventually left the school because no opportunities had been given to stimulate their professional growth. Engelbrecht (2006) reported on how the lack of meaningful leadership leads to low morale of personnel.

According to Bailey and Du Plessis (1997), in Australia, school principals have a significant role in implementing policies in schools and the enrolment of learners with disabilities depends on the attitudes of the school principals. Bailey and Du Plessis (1997) found that, although they adopted the philosophy of inclusion on the basis of a human rights perspective, school principals still have doubts that it will benefit the non-disabled learner. However,

principals are in a powerful position to apply national policies at school level that determine if therapists can supply their support to ordinary schools or not. *In the findings of this study, by not developing a policy that promotes inclusionary principles, the principal acted as a barrier, preventing therapists from providing their support to other schools (See Section 5.4.2.1).*

5.4.6 Relationships with educators

Therapists who were part of this study indicated that the barriers they experienced in their relationships with educators at the full service schools were because of educators being under stress and because the educators were not prepared to work in full service schools.

In this study, therapists indicated that although they could change the environment at the school, educators still see the classroom as their domain and would not allow any changes in the classroom. Some educators also refused to be assisted by the therapists. However, therapists continued to work with the educators who had a positive attitude, hoping that the unwilling educators would eventually be drawn into co-operating with the therapists. Therapists wanted to offer advice in order to provide educators with a more effective teaching approach that would benefit the learner. However, some educators felt threatened and incompetent and perceived it as extra work, whereas the therapists' purpose was to alleviate or make the educators' task easier. Some educators may have been experiencing too much stress to take in more information even if the therapists were saying useful things. This may indicate that therapists should consider a different approach, such as stress reduction techniques, in order to be heard. However, the therapists' approach could have been perceived as being "bossy" and adding extra work to their already overwhelming task. These different perceptions indicate *a lack of adequate communication that lead to misunderstandings, which eventually creates a barrier to therapists' support provision.*

According to Sekerak et al. (2003), the success of the integration of therapy services into the classroom depends on the relationships between educators, physiotherapists, parents and other professionals. The relationship with educators is described as the foundation for successful integration. An effective relationship is characterised by collaboration, co-operation, communication and support (Sekerak et al., 2003). An integrated approach to support delivery ensures a holistic method, with functional activities, and can be achieved if disciplines move away from multidisciplinary or interdisciplinary work to a more collaborative approach (McQueen & Mackey, 1998).

Therapists indicated that they understand the difficulties educators are experiencing in an inclusive education system. These difficulties include big classes of more than 50 learners. Learners are sometimes on four to five different levels in one class as well as speaking three different languages in the classroom. Educators might feel overwhelmed and overburdened by these difficulties. The educators experience even more stress if a learner needs individual attention with toileting and lifting procedures, especially if they have no additional support. All these factors can influence the educators' attitude towards inclusive education negatively and educators might not want to accommodate therapists in the classroom. *Educators' negative attitudes towards having therapists in the classroom are perceived to create a barrier to therapists' provision of support.*

Therapists felt that the educators at the full service school were not properly prepared to work in an inclusive system and they were not given a choice as to whether to become a full service school or not. Therapists indicated that if educators were better prepared for what to expect about their roles relating to the learners with diverse learning needs and those of the therapists' in a full service school, it would facilitate the support provision of therapists to the full service school. In this study, the poor preparation of educators in full service schools to work with therapists was reported to have created a barrier to therapists' provision of support.

Analysis of the literature consulted shows that although educators are generally positive towards inclusion, some are not, and although they adopt the philosophy of inclusion, they worry about how it will affect the learners with no disabilities (Marshall, Ralph, & Palmer, 2002). According to Marshall et al. (2002), educators expressed the lack of knowledge to work in the inclusive classroom and the need for training. Moberg and Savolainen (2003) indicated that educators are key resources to make inclusion a reality, but they can also become the key barrier to inclusion. They also state that the lack of resources and training support for ordinary class educators is a much greater threat to successful inclusion than educator attitudes (Moberg & Savolainen, 2003).

5.4.7 Relationships with parents

Therapists indicated that it is difficult to build relationships with parents if they do not attend meetings. Therapists said that sometimes the only contact they have with the parents is at the time of the admission of the learner to the special school and that only a few parents show interest in their children throughout the year.

Therapists indicated that parents' supportive role in their children's lives usually affects the outcome of therapists' support to learners. Parents need to continue therapy and make adjustments at home. If they do not continue with the activities, the support provided to the learner will not be adequate. *Parents that are not actively involved in their children's lives act as a barrier to therapists' support provision to the learner.*

Other factors which act as barriers to learning in the learner's home environment include family dynamics, cultural factors and the socio-economic status of the family (DOE, 2005a). According to a UNESCO report (2003), socio-economic factors that place learners at risk are unemployment, poverty, HIV/AIDS, violence and abuse (DOE, 2005a). Moletsane (2004) stated that parents are their children's first educators and that social relationships start within the family. The active involvement of parents is central to effective learning and development and parents need to be recognised as partners and a central resource to the education system (DOE, 1997). Therapists need to acknowledge parents and the learners as partners in order to facilitate their support provision (Struthers, 2005b).

5.5 FACILITATORS TO EFFECTIVE SUPPORT

The facilitators therapists experienced when providing support to other schools were related to therapists' roles with the learners and educators, capacity development, networking, intrinsic and extrinsic factors related to therapists, the district-based support team, and relationships with the principals and the educators.

5.5.1 Therapists' roles in relation to learners

The results of this study show that therapists' competencies, including knowledge and skills to do appropriate assessments, facilitated their support provision to the full service school and the special school.

Therapists indicated that their assessments of learners were, firstly, to assist with placement of learners in ordinary schools, and secondly, to empower educators at the full service schools so they can identify and reduce barriers of learning. According to the Department of Education (2008), the National Strategy on Screening, Identification, Assessment and Support (SIAS) provides the tools to screen and identify learners who experience barriers to learning and a support package to address these barriers to learning. Therapists, as part of the district-based support team, will have to know how to use the guidelines of the National Strategy on Screening, Identification, Assessment and Support.

According to Struthers (2005b), therapists can play an important role in developing a safe and supportive teaching environment, which is the second component of the health-promoting schools, framework. Therapists also assess and adapt the environment to allow learners to access the curriculum. The adaptations include advising the schools where ramps and rails would be necessary in and around the buildings, adjusting toilets and basins, and adapting the playground and the classroom. Barriers in the physical environment have been recorded in the literature as inadequate space (Jirikowic et al., 2001) and inaccessibility of building structure, the classroom and equipment (Hemmingsson & Borell, 2002; Lazarus et al., 1999). Pivik et al. (2002) suggested that individuals with disabilities need to be involved in the planning stages of public facility development, which is a good idea since they are able to provide information because of firsthand experience. *Therapists' competencies to change environment and to make it more accessible for learners with disabilities acted as facilitators to their support to the full service schools.*

Therapists indicated that they were prepared to be available to give telephonic advice to educators and learners. This also involved referring learners, who were attending ordinary schools, to the Western Cape Rehabilitation Centre if they needed assistive devices. *Therapists' availability to provide ongoing support to learners (after they have left the special schools to attend the ordinary school) was thus shown to act as a facilitator to therapists' support provision.*

5.5.2 Therapists' roles in relation to educators

According to the findings of this study, therapists were supporting educators by *adapting the curriculum and facilitating access to the curriculum, which acted as a facilitator to therapists' support provision to other schools.*

Therapists indicated that they acted as consultants by assisting and advising educators with problems that learners experienced. This involved discussing with and showing the educators how to adapt the curriculum in order to help learners to access the curriculum. Different aspects of the curriculum that may act as barriers to learning include factors such as content, language or medium of instruction, the organisation and management in the classroom, the methods and processes used in teaching, the pace of teaching and time available, the learning materials and equipment, and the assessment procedures (DOE, 2005a).

UNESCO (2003) reported that the curriculum has been unable to meet the needs of a wide range of different learners. UNESCO (2009) pointed out that the level of learning is lowest in developing countries. In a 2007 survey in India, fewer than half the learners in Grade 3 could read a simple text and only 58% could subtract or divide. Fewer than 25% of Grade 6 learners reached the desirable level of reading in Botswana, Kenya, South Africa, and Swaziland and fewer than 10% in Lesotho, Malawi, Namibia, Uganda and Zambia.

Therapists indicated that their competencies to act as consultants to educators can minimise the barriers to learning as they could adapt the content and the presentation of the curriculum and the development of programmes. In this study, occupational therapists indicated that they were assisting educators with behaviour management strategies, speech and language therapists were helping educators with language development and alternative augmentative communication, and physiotherapists were assisting educators in adapting physical activities.

A qualitative study done by Pivik et al. (2002) showed that learners with physical disabilities in a mainstream school were excluded from the physical education classes, because educators did not understand their physical limitations or were too busy to adapt the curriculum. Participants suggested having special education classes for learners with disabilities and having everyone playing wheelchair or chair basketball. Although having separate physical education classes would suggest segregation, according to Pivik et al. (2002, p. 103), having wheelchair basketball would “equalize the playing field for everyone”.

Therapists also indicated that if educators are open and willing to accept their support, it actually facilitates their support provision. *Training of educators, they maintained, acts as a facilitator to therapists’ support provision.* Therapists indicated that they played an important role in providing training to educators in ordinary schools to help them understand about the disabilities learners have or experience. This was done by giving talks to the educators in ordinary schools about learning difficulties and postural problems. Therapists organise workshops to provide information to educators and to develop their skills to enable educators to identify, to minimise and to remove barriers to learning. Training of educators, especially in preparation for inclusive education, has been emphasised in the literature (Aniftos & McLuski, 2003; Mahon & Cusack, 2002). Engelbrecht et al. (2001) reported that educators felt that their pre-service and in-service training is inadequate to prepare them for inclusive education, and that adapting the curriculum to meet the learners’ needs is stressful, but one of the coping strategies is to contact colleagues or support personnel, for example, the school

psychologist. In this study, therapists indicated that training enables educators to understand the roles of the therapists in the ordinary school and how therapists can support them with learners' needs. This might encourage educators to contact therapists for advice.

5.5.3 Therapists' roles regarding capacity development of student therapists.

Therapists who were interviewed in this study claimed that they also developed the capacity of student therapists and were involved with networking in the community.

The positive arrangement that exists between the special and the ordinary school acts as a facilitator which allows student therapists to do their practical work at the ordinary school.

As student therapists are not yet experienced enough to develop a consultant-mentor relationship, occupational therapy students use direct support at the ordinary school. According to Lindsay (2003), the consultants from the medical field will need to have had extensive training, experience and continuing hands-on experience in their specialities, which excludes inexperienced therapists at entry level from working in schools. However, tertiary institutions in South Africa do not make adequate provision to prepare therapists to act as consultants in schools because the focus of training is still on the medical model of support with the emphasis on how to give one-on-one direct support (Struthers & Lewis, 2004).

5.5.4 Therapists' roles regarding networking.

According to Struthers (2005b), therapists can play an important role in strengthening community action and building the network between the school and the community, which is the third component of the health-promoting schools framework. Therapists need to form partnerships with different sectors in the community, not only the schooling community, but also sectors of health, welfare, non-governmental organisations, parents and voluntary workers (DOE, 2005a). In this study, therapists reported that they formed partnerships with the farmers to bring parents to school meetings in which they could exchange valuable information with the parents. *The partnership that therapists formed with the farmers, as a resource in the community, acts as a facilitator to therapists' support provision to the parents.*

5.5.5 Facilitators related to intrinsic factors

Analysis of the findings of this study indicates that the skills of therapists provide them with confidence and act as a facilitator to therapists' support provision.

Therapists indicated that *training acted as a facilitator or as an important support factor to provide them with the necessary skills, to become better consultants and to better other skills in their specific fields*. Therapists also expressed confidence in themselves as specialists in their own field and a positive attitude to learn from educators, which contributes to the facilitation of support provision to other schools.

5.5.6 Facilitators related to extrinsic factors

Extrinsic factors that the therapists in the study regarded as facilitators included time, formal meetings with the full service schools and peer support obtained during meetings with other therapists.

Some therapists indicated that time is not a barrier since they acted as consultants, and an hour after contact time was sufficient to advise the educators. Therapists also indicated that in spite of lack of human resources, they continued to provide their support and that time should not be a barrier to support provision.

Therapists considered that meetings with personnel at the full service school and peer support acted as facilitators to their support.

Therapists reported that meetings acted as a tool for communication and had been a valuable and important support factor for therapists to provide their support to the full service schools. These meetings included meetings with educators and other therapists at the full service schools. Meetings provided an opportunity to discuss problems and to evaluate if therapists were effective regarding their support provision to the full service school. Communication forms the basis for the collaborative relationship between educators and therapists (Sekerak et al., 2003). Therapists indicated that they attended regular meetings with other therapists, where they could exchange information and learning experiences and support one another. As one therapist mentioned, therapists of different districts should come together so that they can share their experiences in inclusive education. Therapists indicated that had they known better, they would have approached a particular problem differently and *thus meetings with therapists in other districts can act as an important facilitator to their support provision*.

A study done by Barnes and Turner (2001) indicated that collaborative team practices may occur within the educational environments as well as during formal team meetings. Participants in their study voiced their frustrations about the infrequency of formal meetings

and the difficulty in scheduling meetings with occupational therapists (Barnes & Turner, 2001). Furthermore, it was found that when educators and occupational therapists were able to have their frequent scheduled formal meetings, the individual education plan (IEP) objectives decreased, which indicates that as the level of collaboration increased, the number of IEP objectives met decreased. This could be due to more frequent formal meetings that resulted in scrutiny of IEP objectives and to everybody accepting more accountability for IEP objectives (Barnes & Turner, 2001).

5.5.7 Facilitators related to district-based support teams

Therapists who participated in the current study indicated that the district-based support team and the learner support educator, in particular, can act as facilitators by co-ordinating and supporting therapists' support provision.

Therapists claimed that the district-based support teams have the potential to co-ordinate therapy services to other schools so that resources can be used optimally. *They also indicated that the learner support educator acted as a facilitator to therapists' support to both an ordinary farm school and a full service school.* Therapists met with difficulties, such as communication problems, when they started working at the full service school. The learner support educator, as part of the district-based support team, had already built a relationship with the therapists when they delivered their support to the ordinary farm school. The learner support educator was therefore able to play a valuable role in advocating for the therapists' place in the full service school. Therapists indicated that the learner support educator understood the roles of the therapists and could therefore explain their roles to the educators from an educator's perspective, thus helping to lay the foundation for their work at the full service school.

According to the Education White Paper 6 (2001), the district-based support team must be established to provide a co-ordinated professional support service that uses expertise in further and higher education, local communities and special schools. Special schools will act as resource centres to allow ordinary schools to provide a fuller service, called full service schools, to meet the needs of learners with disabilities (DOE, 2005a).

5.5.8 Facilitators related to the principals

Therapists partaking in this study indicated that the principal can act as a facilitator by encouraging therapists to provide their support to other schools. *The principal's role as a*

facilitator to therapists' support provision was reflected when the principals were actively involved by motivating and organising projects regarding inclusive education. Therapists indicated that if principals play an interactive role by motivating and supporting projects, more educators, whose co-operation is also important to therapists' support provision, will become involved. The literature indicates that principals have a position of power that determines the success of the implementation of inclusive education at their schools (Bailey & Du Plessis, 1997; Engelbrecht, 2006). Bailey and Du Plessis (1997) stated that principals are central in the implementation of school innovation and policy, which indicates that the principals' positive input towards the implementation of inclusive education facilitates the therapists' provision of support and the success of community projects. Engelbrecht (2006) also found that if the principal is not involved, inclusionary measures are difficult to implement.

5.5.9 Relationships with the educators

Therapists who were interviewed during this study indicated that their relationships with the educators in the special schools depended on educators understanding the therapists' roles and their team effort to provide support. Therapists pointed out that the educators did not always understand the therapists' roles. There were misunderstandings and conflict initially, but over the years, they have been building positive relationships as they began to understand each others' roles better. This has resulted in a holistic approach to the learners, where therapists and educators reinforce each others' roles, which can only benefit the learner. Therapists indicated that they can now provide their expertise to the other schools as a team (educators and therapists). *This positive relationship with the educators at the special school has acted as a facilitator to therapists' provision of support by attempting community projects through a team approach.*

Therapists indicated that the factors that affected their relationships with the educators at the full service schools included educators' attitude and training of educators. Although they were initially met with scepticism, many therapists described their relationship with educators at the full service schools as positive. The educators' attitude changed when therapists' roles were fully understood and even more so when they found out that the therapists could be of great value to them in reducing barriers of learning. Therapists indicated that educators welcomed the training given to them when learners with disabilities were admitted to their schools. These training sessions created opportunities to build positive relationships amongst

therapists and educators. A study done by O'Toole and Kirkpatrick (2007) showed that interdisciplinary training can promote the collaborative relationship between allied education and health professionals. *The educators' positive attitude and the training provided to the educators acted as facilitators to therapists' provision of support.*

5.3.10 Summary of Section B

In Section B, the findings presented in the previous chapter in order to address Objectives 2 and 3, which were to determine the barriers and facilitators therapists experience regarding their support provision in an inclusive education system, were discussed.

The *barriers* that prevented therapists from effective support provision to ordinary and full service schools included not informing the community of what is available at the special school/resource centre, therapists' uncertainty about their roles, the lack of networking, and the lack of certain competencies, including a lack of knowledge and of skills to adapt the curriculum. Intrinsic factors related to therapists that caused barriers to therapists' support provision were therapists' lack of skills and therapists' negative emotions. These negative emotions, such as frustration, were caused by the following barriers: lack of training and guidance by the district-based support teams, delayed response of the district-based support team when requesting for a full service school to work with, lack of skills to perform as consultants, educators' different expectations of support provision, educators' negative attitudes, poor communication amongst role players, and the lack of policy at school level. Therapists also experienced feelings of powerlessness because of autocratic leadership styles and exclusion from district-based support teams and joint decision making. Therapists' feelings of guilt, due to concern to support learners at the special schools, caused a barrier to their support provision to learners in other schools. Therapists also experienced being based at the special school as a barrier. Extrinsic factors related to therapists that caused barriers to therapists' support provision were the lack of human resources, insufficient time, and the cost of therapists' capacity development. When circuit boundaries affected communication between the key role players at the special school and the full service school, this acted as a barrier to the provision of support. The principal, identified in the survey, acted as barrier when he refused to grant permission to therapists to start community projects. Therapists' relationships with the educators at the special and the full service schools demonstrated how negative attitudes of educators, communication problems between educators and therapists, and educators not being prepared for work in full service school formed barriers to support

provision. The relationships with the parents reflected how parents' non-involvement with their childrens' therapy formed a barrier to therapists' support provision.

The *facilitators* to effective support provision to learners that were identified in this study included therapists' competencies, including therapists having the knowledge and the skills to do appropriate assessments, adapting the environment and their availability to provide ongoing support to learners. Facilitators associated with the therapists' roles in providing support to the educators included therapists' competencies to adapt the curriculum, making it more accessible to learners; therapists competencies to act as consultants; provision of training to enhance educators' understanding of therapists' roles; and educators' positive attitude to accept support. A positive arrangement between the special school and the ordinary school acted as a facilitator that allowed student therapists to do their practical work at the ordinary school. The partnership that therapists formed with the farmers, as a resource in the community, acted as a facilitator to therapists' support provision to parents. Extrinsic factors that facilitated therapists' support provision were formal meetings at the full service schools and peer-group support, and some therapists saw time as a facilitator because of indirect support using consultation. Training to enhance therapists' skills acted as an important facilitator. The following facilitators were highlighted: the co-ordinating role of the district-based support teams, the positive relationship with the learner support educator, the positive relationships with the educators, and the principals' supportive role.

In the next chapter, the conclusion, limitations and recommendations of the study are presented.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

In this section, the summary, significance, limitations, conclusion and recommendations of the study are presented.

6.2 SUMMARY AND CONCLUSION

Inclusive education became a global movement as different countries agreed to the Salamanca Statement on special needs education, which emphasises the importance of education for all children, especially for children with disabilities. The Statement also states that the success of inclusive education lies in the provision of support services which can be provided by the personnel of special schools, for example, therapists. Because tertiary institutions are training therapists in the medical model of support, the goals of therapists' support provision in special schools are more therapeutic than educational. However, therapists internationally have been mandated by changing legislation related to inclusive education to change their model of support to an educational or a health-promoting model.

In South Africa, Education White Paper 6 on Special Needs Education (2001): Building an Inclusive Education and Training System was written based on some of the recommendations of the NCESS/NCSNET Report, which promoted an inclusive education system for all learners, including learners with disabilities. The Report indicated that in order to recognise and address the diverse needs of the learner population, the barriers to learning need to be identified. Education support services, including therapists, can play a role in preventing, identifying and reducing barriers to learning and development. Therapists, as part of the district-based support teams, will provide their support to full service schools. The re-orientation of support services has been suggested, that is, a move from a curative, problem-orientated approach to a more preventative, health-promotive and developmental approach. According to Struthers (2005b), therapists can provide their support by using the five strategies of the health-promotion framework of the Ottawa Charter. The study done by Struthers (2005b) indicated that therapists in South Africa were using the medical model of direct support to a greater extent than the health-promoting model of indirect support.

The main aim of the study was to determine if therapists are changing their model of support in building inclusive and health-promoting schools, and to determine the barriers and facilitators they experience when providing their support in an inclusive education system. Objective 1 was to explore whether therapists were working in the medical model of support or in a health-promoting model of support. Objective 2 was to describe the barriers to therapists' support and the influence on therapists' support provision to ordinary and full service schools. Objective 3 was to describe the facilitators that promoted success in therapists' provision of support.

The literature review provided an overview of past research on the topic and described inclusive education from a human rights perspective. It described the development of inclusive education internationally and in South Africa, and therapists' role in education support services. The role and the different models of support were discussed and an analysis indicated that the re-orientation of support services is necessary in order to function in an inclusive education system. Legislation has led to a move towards inclusive education internationally, and this has encouraged therapists to change their model of support from a medical model of direct support to a consultative model of indirect support. The two main models of support, namely direct and indirect support, were discussed, focusing on the medical model, the health-promoting model and the different team approaches, namely, the multidisciplinary, interdisciplinary and consultative collaborative approaches. The barriers and facilitators were discussed, including the value of a collaborative relationship in therapists' support provision to the ordinary and the full service school.

In Chapter Three, the research design describes the quantitative and the qualitative methodology used in this study. The quantitative method used a survey which included therapists from the special schools of the seven districts (EMDCs) in the Western Cape. Qualitative data collection procedures included three focus group discussions at three different special schools, in three different EMDCs.

Objective 1 was addressed by the findings of the survey, which indicated that therapists played different roles by giving direct support, indirect support and developing their own capacity as well as those of others.

Comparing the findings of this study with that of Struthers (2005b) confirmed the traditional roles of the different disciplines, namely, that occupational therapists still focused mainly on assessing and providing support to develop learners with motor, intellectual and learning

disabilities; physiotherapists assessed and provided support to develop learners with motor impairments; and speech and language therapists focused on the assessment and development of learners' hearing, speech and language impairments. Therapists' roles were shown to have become more defined; for example, speech and language therapists and physiotherapists only shared one activity, namely, teaching parents feeding techniques. The speech and language therapists' activities in direct support, including developing the skills of activities of daily living, life skills, skills in home management, motor function activities, and community mobility were shown to have reduced. Speech and language therapists had decreased their indirect support activities by no longer giving support to educators and parents regarding assistive devices. On the other hand, this study indicated an increase of 31% of physiotherapists who provided equipment to the educators. Struthers (2005b) reported that 33% of physiotherapists were teaching parents on hearing aids and FM maintenance, but this study showed that physiotherapists were no longer doing that.

The findings related to addressing Objective 1 indicated a general decrease in direct activities and a slight increase in indirect support activities.

Occupational therapists were still predominantly playing a role in work and productive activities and home management skills but fewer occupational therapists were involved in all these activities. The reduction of direct support activities was also noticeable in occupational therapy and physiotherapy. Although the majority of occupational therapists and physical therapists were still involved in the developing of play and leisure activities for learners with disabilities, 2%-21% fewer therapists were doing these activities compared to Struthers' (2005b) findings. This reduction in involvement in some of the direct support activities may imply that a slight shift from direct intervention to more indirect support was taking place. Although 27% more physiotherapists became involved in community mobility, 30% fewer occupational therapists, who still played a dominant role in developing home management skills, were involved in money management activities. Additionally, 43% more occupational therapists were doing special seating positioning for learners with disabilities.

This study showed that the majority of speech and language therapists have changed to working with individual learners. This is more intensive work and might explain why speech and language therapists have "withdrawn" from other activities and focused more on developing hearing, speech and communication skills.

There is still no change in the collaborative activities of therapists. Therapists still include other therapists more often when doing the initial planning of assessments and treatments than when evaluating the outcome of support. In this study, the majority of therapists reported that they “always” involved therapists of their own profession and only “sometimes” included other disciplines in assessment of learners’ needs and the evaluation outcome of their intervention. This finding implies that collaboration is not taking place effectively and that therapists still confine the collaboration process to amongst themselves and only sometimes allow other professions into the initial planning of their support.

The study, like that of Struthers (2005b), indicated that therapists are more focused on working in the special schools than on providing their support to ordinary schools. Very few therapists gave individual or group support to educators in ordinary schools or educator support teams. The majority of therapists indicated that they never gave individual or group support to the educators at the EMDC or the school clinic. These findings imply that therapists limit their provision of support to educators.

However, the findings indicate that therapists are increasing their indirect support activities but not sufficiently to balance it with direct support. Therapists are increasing their activities in using a more health-promoting framework. Therapists have increased their curriculum support to the educators, and 8%-31% more occupational therapists and physiotherapists provide educators with more equipment than before.

Because therapists were mainly focused on support provision to the special schools, therapists had more contact with parents in the special school than in other schools. This is another indicator that therapists’ support to other schools is inadequate. Therapists maintained they provided their support indirectly to the learners by providing information to parents, developing parents’ skills, and assisting parents in their homes. More than 50% of physiotherapists and occupational therapists (Struthers: 43%) reported that they did home visits and 76% of physiotherapists (Struthers: 58%) helped with home adaptations.

Comparing the findings with those of Struthers, 2%-22%, more therapists were shown to have become involved in sharing information with learners in ordinary schools about disability, 18%-32% more therapists shared information with learners about inclusion, and 5%-12% more therapists became involved with the visits of learners from ordinary school to the therapy department at the special school. Furthermore, 8%-27% more therapists increased their support to the community by giving information regarding organisations that provide

assistance, and 9%-11% more therapists gave information to the community regarding the rights of children with disabilities.

In conclusion, the findings of this study indicate that therapists are still operating in the medical model at the special school, but with a more holistic approach. Other indicators that suggest that therapists are still operating in a medical model of support by using direct care is that the majority of therapists reported they often used the school therapy department and “occasionally” gave their support to learners in the classroom and school playground. The majority of occupational therapists and speech and language therapists never worked at the learners’ home. Therapists also indicated that they are still using more direct support (62%) than indirect support (38%).

In order to address Objectives 2 and 3, three focus group discussions were held, and the following themes related to the barriers and facilitators emerged: the roles of therapists, intrinsic and extrinsic factors related to therapists, the roles of the district-based support teams and the principal, and the relationships of therapists with the educators and the parents.

The barriers that therapists experienced were mainly created by their own insecurities about the roles that they are supposed to play in an inclusive system, the frustrations, the feelings of powerlessness, and the feelings of guilt. Other barriers included the lack of human resources and the lack of time, lack of networking, lack of skills and lack of training. The barriers related to the district-based support teams were created by structural boundaries that caused a lack of communication and a lack of training provision for therapists. The barriers related to the principal were the authoritative management style, which represses the therapists’ professional growth; the rejection of ideas for community projects; and the lack of policy at school level. The barriers that therapists experienced in their relationship with educators were mainly based on misunderstandings about therapists’ roles, unco-operative and stressed educators, and educators’ different expectations. The barriers that therapists experienced regarding their relationship with parents were based on parents’ non-involvement that negatively influenced therapists’ support to the learners. Therapists also experienced being based at the special school as a barrier.

The factors that facilitated therapists’ support (Objective 3) included the confidence that therapists have in their competencies, which indicates how important training is. Facilitators included the positive partnerships therapists formed with the community, meetings with other role players and therapists, the supporting role of the learner support educator (district-based

support team), and the active leadership or supporting role of the principal. The facilitators that came from the relationships with educators were the educators' positive attitude, training for educators, and the reinforcement of each others' work.

6.3 SIGNIFICANCE OF STUDY

The White Paper 6 on Special Needs Education: Building an inclusive education and training has been written. This study provides information on therapists' involvement in the implementation of inclusive education. The study identified to what extent therapists have changed their approach of support in developing inclusive and health promoting schools.

The findings of this study can be used for the training and the capacity development of therapists as the role of therapists and their practice have been explored. The barriers and facilitators that therapists can encounter have been identified in the study. This information is valuable for educational institutions to prepare students to obtain skills needed as a team member in an inclusive education system. The findings of the study can assist therapists to make the transition from a medical model of support to a health promoting model of support.

The findings of this study can be used to inform the Department of Education of existing barriers preventing the provision of therapeutic support and the supportive factors that contributed to the successes of the implementation of inclusive education in a consultative manner.

6.4 LIMITATIONS

1. The extent to which the results can be generalised to the whole schooling community of South Africa is limited since there are more special schools in the Cape Metropole than in some other parts of the country. Education support services and resources are not as accessible in the rural areas as in the urban areas.
2. The results of the focus groups cannot be transferred to other settings or groups since the sample is too small to represent a larger population.
3. This is a cross-sectional study and data was taken at a single point in time, which means that data may change over a longer period of time.

6.5 RECOMMENDATIONS

The following recommendations are made on the basis of the findings:

1. Tertiary institutions need to accommodate the roles of school-based therapists in an inclusive education system in their curriculum and need to focus on the principles of the health-promoting model of support.
2. Therapists working in special schools, who are not experienced, need to be linked to a mentor and need to build a mentoring relationship with a therapist that is more experienced. Therapists need to develop their skills to be consultative collaborators and advocates for the learners and families.
3. The Western Cape Education Department has an obligation to include therapists in training on the curriculum because some therapists indicated that they do not know how to work in the curriculum. The district-based support teams must also play their part in the re-orientation of therapists in their new roles as consultants.
4. The Western Cape Education Department must give attention to schools where therapists are not subsidised for their therapy-related courses. Financial support would motivate therapists to continue their professional development and improve the quality of their service provision to the school community.
5. Training for educators is necessary to prepare them for their roles in the inclusive classroom and in understanding the role of school-based therapists. This can prevent the communication problems and the conflict that therapists and educators experienced. Interdisciplinary training would be valuable.
6. Therapists should be part of the district-based support team, as indicated by the Education White Paper 6 (2001), to allow therapists to form part of the decision-making process regarding policies and practices of inclusion. Therapists also need to form part of school governing bodies and school committees to influence policy at school level.
7. Principals need to change their management styles and their vision about inclusion so that policy (Education White Paper 6) can become practice in their schools.
8. Partnerships with parents and learners need to be formed so that there is a continuation of therapists' provision of support to the learner at home.

9. Partnerships need to be formed with the community in order to draw from these resources, and collaborative relationships need to be formed with other sectors in the community.



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UNIVERSITY *of the*
WESTERN CAPE

APPENDIX 1

Respondent number:

| | |
|--|--|
| | |
|--|--|

EMDC _____

Your current employment

Please tick all relevant answers, you may need to tick more than one box for each question

Q1. I am qualified as:

- An occupational therapist
- A physiotherapist
- A speech and language therapist

| |
|--|
| |
| |
| |

Q2.

a. I work in the state sector

| | | |
|---|-----|----|
| In the Western Cape Education Department: WCED post | Yes | No |
| School governing body post | Yes | No |
| Private practice | Yes | No |
| Other (please specify) | Yes | No |

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 at the schools you work in. Information about private practice is not applicable. (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

Q3. 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 5.

Q4. 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 | |

Q5. 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)

Q6. 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)

Q7. Do you work with learners?

| | | | |
|--------------|-------|--------------|-------|
| Individually | Often | Occasionally | Never |
| In groups | Often | Occasionally | Never |

Q8. 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)

Q9. 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 |

Q10. What direct learner support have you, yourself, provided in 2007? (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, Braille writer, computer) | |
| Reading and spelling remediation | |
| Visual perception skills | |

Other (please specify)

Q11. 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)

Q12. 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)

Q13. Home management

| | |
|---|--|
| Clothing care (obtaining, laundering, ironing, mending etc) | |
| Cleaning the home | |
| Meal preparation and cleanup | |
| Shopping | |
| Money management | |

Other (please specify)

Q14. 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)

Q15. Motor function activities

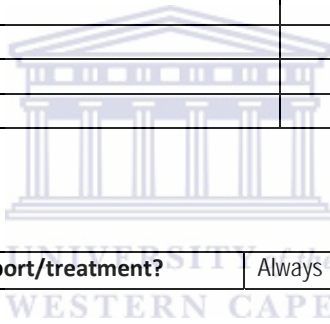
| | |
|---|--|
| Fine motor functional activities | |
| Gross motor functional activities | |
| Motor co-ordination activities | |
| Posture correction | |
| Seating positioning in classroom | |
| Alternative positioning in school (standing, lying) | |
| Other (please specify) | |

Q16. Counseling

| | | |
|--|-----|----|
| Are you involved in formal counseling of learners? | Yes | No |
|--|-----|----|

Q17. 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 (organization, training etc) | |
| Hydrotherapy | |
| Horse riding | |
| Dance therapy | |
| Extra-mural activities (e.g. choir) | |
| Other (please specify) | |



| | | | |
|--|--------|-----------|-------|
| Q18. Do you evaluate your direct support/treatment? | Always | Sometimes | Never |
|--|--------|-----------|-------|

Q19. If always or sometimes:

| | |
|--|--|
| I use regular assessment procedures | |
| I assess whether the goal was achieved within the proposed timeframe | |

Q20. 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) | |

Q21. 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 |

| | | |
|--|-----|----|
| Q22. Do you refer learners to therapists outside the school for direct support/treatment? | Yes | No |
|--|-----|----|

If your answer is **yes**:

Q23. 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**:

Q24. 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. 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

Q25. Do you give support to teachers?

| | Individually | | | In groups | | |
|--------------------------------------|--------------|-----------|-------|-----------|-----------|-------|
| | Often | Sometimes | Never | Often | Sometimes | Never |
| Teachers in special schools | | | | | | |
| Teachers in ordinary schools | | | | | | |
| Teacher support teams at schools | | | | | | |
| Teachers at the EMDC/(school clinic) | | | | | | |

Q26. What support do you provide to 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 | |

Q27. 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 | |

Q28. 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) | |

Q29. 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

Q30. 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 to parents?

Q31. 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 learners' progress in therapy | |
| Other (please specify) | |

Q32. Support in homes

| | |
|--|--|
| 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) | |

Q33. 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) | |

Q34. Emotional support

| | |
|--------------------------------|--|
| Formal counselling for parents | |
|--------------------------------|--|

c. Therapists support for the general learner population

Please tick all relevant (v) answers, you may need to tick more than one box for each question

Q35. Support for learners in ordinary school

| | | |
|---|-----|----|
| Provision of information on disability | Yes | No |
| Provision of information on the rights of people with disability | 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 (v) answers, you may need to tick more than one box for each question

Q36. Indicate what adaptations to the school environment you have organised:

| | |
|-----------------------------------|--|
| Ramps | |
| Rails | |
| Adaptations to toilets and basins | |
| Adaptations to school classroom | |
| Adaptations to school playground | |

Other (please specify)

Q37. Indicate what aspects of management are you involved with:

| |
|---|
| Administration/record keeping related to support of learners for therapy department |
| Influencing decisions on policy |
| Multidisciplinary team meetings including teachers |
| Meetings with EMDC/ school clinic |
| Meetings NGO / welfare organisations |
| Member of school governing body |
| Organising / participating in fundraising activities for special school |

Other (please specify)

e. Therapists support of the curriculum

Please tick all relevant (v) answers; you may need to tick more than one box for each question

A flexible curriculum enables learners to participate in the learning process.

Q38. Indicate how you have been involved in curriculum development

| | | |
|--|-----|----|
| Adaptation of the curricular content | Yes | No |
| Developing alternative ways of presenting the curriculum | Yes | No |
| Developing alternative ways of evaluation / assessment of learners | Yes | no |

Other (please specify)

Appropriate assistive devices facilitate the removal of barriers by enabling learners to access the curriculum and functional independence

Q39. Which assistive devices do you provide?

| | |
|---|--|
| Hearing Aids (recommendation, fitting and evaluation) | |
| Walking aids (crutches, rolator, walking sticks) | |
| Manual wheelchairs | |
| Electrical wheelchairs | |
| Special seating | |
| Support for standing | |
| Aids for communication | |
| Aids for writing (e.g. computer) | |
| Aids for dressing | |
| Aids for feeding | |

Other (please specify)

Q40. Which assistive devices do you make?

| | |
|--------------------------|--|
| Ear moulds | |
| Arm moulds | |
| Leg / foot splints | |
| Special seating | |
| Special standing support | |

Others (please specify)

Q41. What is your role in the maintenance and repair of assistive devices?

| | |
|---|--|
| I maintain assistive devices | |
| I repair assistive devices | |
| I teach 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 | |

Others (please specify)

f. Community support

Q42. Are you developing the therapy department as a resource centre for therapy? Yes No

Indicate the other support you provide the community:

Q43. 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 regarding the early identification of problems | |

Other (please specify)

Q44. Training

| | |
|--|--|
| Training of community based workers | |
| Training of volunteers to assist in the school | |

Other (please specify)

Q45. Approach used in the community

| | |
|---|--|
| Open days at special school for the community | |
| Talks in the community | |
| Workshops in the community | |

Other (please specify)

Q46. Advocacy

| | |
|--|--|
| Do you participate in local campaign(s) e.g. access to transport/ inclusion in community facilities) | |
|--|--|

Other (please specify)

Q47. Industry

| | | |
|--|-----|----|
| Do you have links with industry/ workplaces? | Yes | No |
|--|-----|----|

Q48. 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 physical disabled | |
| Cerebral palsy Association | |
| SACLA | |
| Interface | |

Others

Section C. This section describes the support you would like to provide learners:

Q49. Using the information that you have provided to the above questions, estimate the % of the time you have spent on the different areas of support in 2007:

(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 management) | |
| • supporting the curriculum (including providing assistive devices) | |
| • in the community | |
| Total | 100 |

Q50. Please reflect on the time you spend on the different categories. Would you like to be allocating your time any differently?

| | |
|-----|----|
| Yes | No |
|-----|----|

Q51. 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 management) | |
| • supporting the curriculum (including providing assistive devices) | |
| • in the community | |
| Total | 100 |

SECTION 3

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

Q52. 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)

Q53. Supervision

| | |
|----------------------------|--|
| By your head of department | |
| By the school principal | |

Other (please specify)

Q54. 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

Q55. 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)

Q56. Support / Mentoring

| | |
|---|--|
| Mentoring / support of student therapists in ordinary schools | |
| Mentoring / support of student therapists in special schools | |

Other (please specify)

Q57. 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:

e-mail:



Navrae **APPENDIX II**
Enquiries
IMibuzo **Dr RS Cornelissen**

Telefoon
Telephone **(021) 467-2286**
IFoni

Faks
Fax
IFeksi **(021) 425-7445**



Wes-Kaap Onderwysdepartement

Western Cape Education Department

ISebe leMfundo leNtshona Koloni

Verwysing
Reference **20080227-0006**
ISalathiso

Ms Josephine Kotze
Department of Physiotherapy
Unveristy of the Western Cape
Private Bag X17
BELVILLE
7535

Dear Ms J. Kotze

RESEARCH PROPOSAL: BARRIERS AND FACILITATORS THERAPISTS EXPERIENCE REGARDING SUPPORT PROVISION IN AN INCLUSIVE EDUCATION SYSTEM.

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, 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. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **27th February 2008 to 27th June 2008.**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Dr R. Cornelissen at the contact numbers above quoting the reference number.
8. A photocopy of this letter is submitted to the Principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Education Research.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

**The Director: Education Research
Western Cape Education Department
Private Bag X9114
CAPE TOWN
8000**

We wish you success in your research.

Kind regards.

Signed: Ronald S. Cornelissen
for: **HEAD: EDUCATION**
DATE: 27th February 2008

MELD ASSEBLIEF VERWYSINGSNOMMERS IN ALLE KORRESPONDENSIE / PLEASE QUOTE REFERENCE NUMBERS IN ALL CORRESPONDENCE / NCEDA
UBHALE IINOMBOLO ZESALATHISO KUYO YONKE IMBALELWANO

GRAND CENTRAL TOWERS, LAER-PARLEMENTSTRAAT, PRIVAATSAK X9114, KAAPSTAD 8000
GRAND CENTRAL TOWERS, LOWER PARLIAMENT STREET, PRIVATE BAG X9114, CAPE TOWN 8000

WEB: <http://wced.wcape.gov.za>

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INDIENSNEMING- EN SALARISNAVRAE/EMPLOYMENT AND SALARY QUERIES ☎0861 92 33 22
VEILIGE SKOLE/SAFE SCHOOLS ☎0800 45 46 47

APPENDIX III



University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY

J.D Kotze
P.O.Box 104
Austinville
Blackheath
7580

The principal

Dear Sir/Madam

Re: Therapists' participation in research

I am a masters' student and I would like to learn more about the support therapists provide in an inclusive education system. My research is firstly, about the model of support therapists are using and secondly, the barriers and facilitators they experience when providing their support to mainstream schools.

The therapists at your school are kindly requested to fill in a questionnaire that will determine the model of support therapists are using. All therapists, that is occupational therapists, physiotherapists and speech and language therapists are welcome to participate in the survey.

I am also doing a test-retest to test the reliability to the answers of that questionnaire. This involves therapists completing the questionnaire twice with an interval of a period of two weeks between the two answering sessions.

I have received permission from the WCED to continue this study in the schools and I gladly attach a copy of it.

Thank you in anticipation.

Josephine Kotze
Cell nr: 0733480782/ 0219051456; e-mail: kadam@xsinet.co.za

APPENDIX IV



University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY

J.D Kotze
P.O.Box 104
Austinville
Blackheath
7580

The therapist in charge

Dear Sir/Madam

Re: Therapists' participation in research

I am a masters' student and I would like to learn more about the support therapists provide in an inclusive education system. My research is firstly, about the model of support therapists are using and secondly, the barriers and facilitators they experience when providing their support to mainstream schools.

The therapists at your school are kindly requested to fill in a questionnaire that will determine the model of support therapists are using. All therapists, that is occupational therapists, physiotherapists and speech and language therapists are welcome to participate in the survey.

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I have received permission from the WCED to continue this study in the schools and I gladly attach a copy of it.

Thank you in anticipation.

Josephine Kotze
Cell nr: 0733480782/ 0219051456; e-mail: kadam@xsinet.co.za

APPENDIX V: RESULTS OF TEST-RETEST

| Question | Variable | Summary agreement before and after self-assessment on a set of questions (%) |
|---------------|---|--|
| Q1 | Qualification | 92% |
| Q2 | Employer | 96% |
| Part A | DIRECT LEARNER SUPPORT | |
| Q3 | Direct support | 81% |
| Q4 | What therapists assess learners for | 88% |
| Q5 | Reason for assessing learners | 93% |
| Q6 | Area therapists work with learners | 72% |
| Q7 | Individual or group work with learners | 88% |
| Q8 | Other therapists at workplace | 93% |
| Q9 | Joint decision making on learners' support needs and treatment. | 69% |
| Q10 | Type of learner support provide in 2007. | 93% |
| Q11 | Activities of daily living/ Self maintenance tasks | 90% |
| Q12 | Life skills/ Social skills | 89% |
| Q13 | Home management | 100% |
| Q14 | Work productive activities: Educational activities | 88% |
| Q15 | Motor function activities | 90% |
| Q16 | Counselling | 69% |
| Q17 | Play or leisure activities | 78% |
| Q18 | Evaluation of direct support | 75% |
| Q19 | Reasons for evaluation 'always and sometimes' | 53% |
| Q20 | Reasons for evaluation 'sometimes or never' | 80% |
| Q21 | Joint decision making when evaluating direct support | 61% |
| Q22 | Referral of learners to therapists outside school | 81% |
| Q23 | Referral to hospital based therapists | 79% |
| | Referral to private practitioners | 88% |
| Q24 | Reasons for non-referrals | 88% |
| PART B | INDIRECT LEARNER SUPPORT | |
| | Support to teachers | |
| Q25 | Support to teachers individually or in groups | 58% |
| Q26 | Curriculum support | 88% |
| Q27 | Support to ergonomics and kinetic handling | 83% |
| Q28 | Support to advocacy | 88% |
| Q29 | Training to non-teaching personnel | 64% |
| | Support to parents | |
| Q30 | Frequency of contact with parents | 77% |
| Q31 | Development of parents' knowledge and skills | 88% |
| Q32 | Support in homes | 80% |
| Q33 | Support to advocacy | 88% |
| Q34 | Emotional support for parents | 94% |

| Question | Variable | Summary agreement before and after self-assessment on a set of questions (%) |
|---------------|---|--|
| | Therapists' support for the general learner population | |
| Q35 | Support for learners in ordinary schools | 54% |
| | Therapists' involvement in developing a supportive environment | |
| Q36 | Adaptations to school environment | 82% |
| Q37 | Involvement management aspects | 80% |
| | Therapists' support of the curriculum | |
| Q38 | Ways of being involved in curriculum | 42% |
| Q39 | Provision of assistive device | 94% |
| Q40 | Manufacturing of assistive devices | 91% |
| Q41 | Therapists' role in maintenance and repair of assistive devices | 90% |
| | Community support | |
| Q42 | Developing therapy department as resource centre for therapy | 75% |
| Q43 | Provision of information | 80% |
| Q44 | Provision of training | 94% |
| Q45 | Approach used in the community | 93% |
| Q46 | Support to advocacy | 100% |
| Q47 | Links with industry/ workplaces | 63% |
| Q48 | Contact with community organisations | 92% |
| Q49 | Proportion of time spent in the present | 46% |
| Q50 | Considering to allocate time differently | 69% |
| Q51 | Proportion of time spent in the future | 71% |
| PART C | CAPACITY DEVELOPMENT | |
| | The development of therapists' capacity | |
| Q52 | Through training | 83% |
| Q53 | By supervision | 86% |
| Q54 | Through support and mentoring | 91% |
| | Therapists' role in developing the capacity of others | |
| Q55 | Through training | 88% |
| Q56 | Through support and mentoring | 96% |
| Q57 | By supervision | 96% |

APPENDIX VI



University of the Western Cape

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2542 Fax: (021) 959 1217

DEPARTMENT OF PHYSIOTHERAPY

J.D Kotze
P.O.Box 104
Blackheath
7580

Dear Occupational therapists, Physiotherapists, Speech and Language Therapists

Re: Participation in research

I am a masters' student and I would like to learn more about the support therapists provide in an inclusive education system. My research is firstly, about the model of support therapists are using and secondly, the barriers and facilitators they experience when providing their support to mainstream schools.

I would like you to fill in the questionnaire to answer the first part of research and if you are interested to participate in a group discussion of five therapists, you are welcome to fill in your details on the last page of the Questionnaire. These focus group discussions will be necessary to determine the second part of the research.

I have received permission from the WCED to continue this study in your schools.

Thank you for taking some of your valuable time to participate in this research.

God bless

Josephine Kotze



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959, Fax: 27 21-959
E-mail:

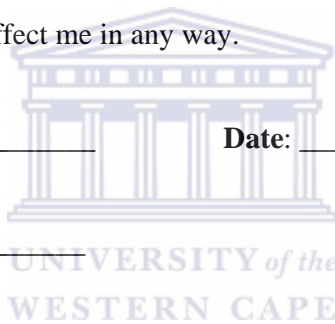
CONSENT FORM

Title of Research Project: Barriers and facilitators therapists experience regarding support provision in an inclusive education system.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name: _____ **Date:** _____

Participant's signature: _____



Should you have any questions regarding this study or wish to report any problems you have experienced related to this study, please contact the study coordinator:

Study Coordinator's Name: Patricia Struthers

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021)959-2542

E-mail: pstruthers@uwc.co.za

Josephine Kotze

53 Meadow Way

Blackheath, 7581

Telephone: (021)9051456

E-mail: kadam@xsinet.co.za



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail:

INFORMATION SHEET

Project Title: Barriers and facilitators therapists experience regarding support provision in an inclusive education system.

What is this study about?

This is a research project being conducted by Josephine Dianne Kotze at the University of the Western Cape. We are inviting you to participate in this research project because you are working as a therapist at a special school in the Western Cape and have the experience and knowledge to contribute to this study. The purpose of this research project is to determine the type of support that therapists are providing to full service schools and to determine what barriers and facilitators exist that prevent and promote the implementation of inclusive and health promoting schools.

What will I be asked to do if I agree to participate?

You will be asked to complete a questionnaire. You will also have a choice to participate in a focus group discussion. The study will take place in all the EMDCs in the Western Cape. Completing the questionnaire should take 20 minutes of your time. The Focus Group Discussion will last approximately one hour. Questions will focus on the model of support provided by therapists in special schools as well as factors that prevent and help the provision of support. See Questionnaire.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, data will be locked in a filing cabinet. Identification codes on data forms and password-protected computer files will be used. The surveys are anonymous and will not contain information that may personally identify you. For coded identifiable information (1) your name will not be included on the survey and other collected data; (2) a code will be placed on the survey and other collected data; (3) through the use of an identification key, the researcher will be able to link your survey to your identity; and (4) only the researcher will have access to the identification key.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

This research project involves making **audiotapes** of participants who will take part in Focus Group Discussions. Only the researcher and her supervisor will have access to it. The audiotapes will be stored in a locked filing cabinet and be destroyed when not in use.

I agree to be audiotaped during my participation in this study.

I do not agree to be audiotaped during my participation in this study.

What are the risks of this research? There are no known risks associated with participating in this research project.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the model of support in which therapists at special schools are operating in order to implement inclusive and health promoting schools. We hope that, in the future, other people might benefit from this study through improved understanding of support therapists provide to ordinary schools.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Josephine Kotze at the University of the Western Cape. If you have any questions about the research study itself, please contact Josephine Kotze at:



Address :

53 Meadow Way, Blackheath, 7581

Telephone number: 021-9051456 / 0733480782

E-mail address: kadam@xsinet.co.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

