FAMILY ENGAGEMENT IN SCHOOL-BASED OCCUPATIONAL THERAPY

THE EXPLORATION OF FAMILY ENGAGEMENT IN SCHOOL-BASED OCCUPATIONAL THERAPY: CONCEPT DEVELOPMENT AND PRACTICE IMPLICATIONS

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment of the Requirements for the Degree Doctor of Philosophy

McMaster University DOCTOR OF PHILOSOPHY (2020) Hamilton, Ontario (Rehabilitation Science)

TITLE: The exploration of family engagement in school-based occupational therapy: Concept development and practice implications

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NUMBER OF PAGES: xvi, 195

LAY ABSTRACT

Pediatric occupational therapists aim to partner with the family in all aspects of a child's service. However, this is difficult for school-based occupational therapists. Families are not typically present at the school when therapists provide services for children, making it difficult to build relationships. This thesis explores factors that impact on how families are able to engage in the school-setting, and on how to provide families with better support. The first study examines how families engage in children's education, and what this means for school-based therapists. The second study explores therapists' views of what influences family-therapist relationships in a school-based service delivery model called Partnering for Change. The final study explores family engagement in school-based occupational therapy from the perspective of both families and therapists. Findings from all three studies contribute to a better understanding of what family engagement means in the school-setting, and how to build stronger family-therapist relationships in school-based occupational therapy services.

ABSTRACT

In pediatric occupational therapy, family-centered service is an essential part of practice. Working with families, occupational therapists facilitate capacity-building to enable parents to participate in their child's occupational therapy services and make informed choices to best support their child. Family engagement can be particularly challenging in the school-based context, but without this engagement, services are at risk of being less meaningful and impactful for children. In this thesis, I explore the unique nature of the educational context, contribute to the conceptual development of 'family engagement', provide an in-depth analysis of family engagement in school-based occupational therapy, and generate stakeholder-informed solutions for occupational therapy practice.

The first manuscript depicts a concept analysis that critically analyzes the concept of family engagement as discussed in the education literature. I suggest implications for professionals working with families and children in educational settings, including a proposed definition to contribute to further concept development.

In the second manuscript, I present a qualitative description study exploring occupational therapists' experiences on the development of family-therapist relationships using the Partnering for Change service delivery model. Through analysis of the data, I identify several factors influencing family-therapist relationships and recommend strategies to improve relationship-building.

In the last study, I present an interpretive description study exploring family engagement in school-based occupational therapy services from the perspectives of both occupational therapists and families. Based on the findings, I recommend service transformation to improve family engagement, and to increase the value of these services for children and their families.

Specific strategies for therapists, organizations, schools, regulatory colleges, and professional practice groups are outlined in this thesis to facilitate family engagement in school-based occupational therapy practice. Ensuring families are able to engage in services may lead to more individualized and impactful services in the school setting.

ACKNOWLEDGEMENTS

I believe finally, that education must be conceived as a continuing reconstruction of experience; that the process and the goal of education are one and the same thing.

– John Dewey

I have been blessed with an abundance of support throughout my PhD journey. Without this unwavering support, it would have taken a miracle to find myself at the end. My journey was a unique one, and I thank Drs. Wenonah Campbell and Cheryl Missiuna for their remarkable supervision at different points along this journey.

Wenonah, I came under your supervision at an unexpected time and I thank you for trusting me to be your first doctoral student. I will be forever grateful for your empathetic and open nature. Your kind heart coupled with your high expectations have made this journey an enjoyable and fruitful experience. I cannot thank you enough.

Cheryl, your guidance and support have encouraged me and lifted me up through some challenging times, both personally and professionally. I am extremely privileged to have been given the chance to train under such a highly respected, and brilliant occupational therapist.

I am honoured that I had the opportunity to have Professor Nancy Pollock on my committee before her passing. Her brilliance and talents were beyond measure.

I am fortunate to have had the guidance of Dr. Sandra Moll as a committee member over the past few years. Sandra, thank you for your thoughtful feedback and methodological expertise which have strengthened the quality of this work.

I deeply appreciate my committee member Dr. Jennifer Yost for always providing a fresh perspective, and thoughtful guidance. Jenny, thank you for your commitment to me, and this work, over the past five years.

A special thank you to Dr. Julie Richardson, and the staff at the School of Rehabilitation Science and *CanChild* Centre for Centre for Childhood Disability Research for their dedication to the student experience. And to the many friends I have made in this program, I will cherish our time together for years to come. Thank you for the study sessions, coffee dates, and strolls across campus.

I am grateful for the financial support I received from Drs. Wenonah Campbell and Cheryl Missiuna, the School of Rehabilitation Science, the Ontario Graduate Scholarship and the Canadian Federation of University Women. Additionally, this work would not have been possible without research funding support from the Canadian Occupational Therapy Foundation.

Most importantly, I am grateful for, and forever indebted to, my friends and family. To my friends, thank you for your patience and understanding, and for the heartfelt wishes along every step of this process. Mom and Dad, thank you for believing in me and standing beside me through all my outrageous ideas, and for endless amounts of love, support, and food. Finally, to my husband, Jordan, your patience knows no bounds. Thank you for insisting that I follow my dreams regardless of the sacrifice. Your support and love are more than I could ever ask for.

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LIST OF ABBREVIATIONS AND SYMBOLS

OSOT – Ontario Society of Occupational Therapists

OTs – occupational therapists

P4C – Partnering for Change

SBOT – school-based occupational therapy

SBRP – school-based rehabilitation providers

SBRS – school-based rehabilitation services

SERTs – special education resource teachers

κ – statistical symbol representing Cohen's kappa coefficient

DECLARATION OF ACADEMIC ACHIEVEMENT

This manuscript-style dissertation consists of three independent research studies (Chapters 2-4) related in subject matter. As the primary researcher and author of these studies, I made significant and original contributions to the development of all three manuscripts. Chapter 2 and 4 were drafted for submission to peer-reviewed journals. Chapter 3 has been published in the British Journal of Occupational Therapy. Details related to my contributions to each manuscript are outlined below:

Chapter 2. The concept of family engagement in education: What are the implications for school-based rehabilitation service providers?

I conceptualized the idea for this study and developed the study's purpose and research question. With guidance from Drs. Wenonah Campbell, Cheryl Missiuna, Sandra Moll, and Jennifer Yost, I chose the best research design to answer the research question. I consulted with a librarian to design and complete a systematic search for relevant literature. I conducted data collection and screening with assistance from Vanessa Tomas as a second reviewer. I led the data analysis and interpretation with co-coding assistance from Dr. Sarah Terreberry, and guidance from Dr. Wenonah Campbell. I prepared the manuscript, with guidance from Dr. Wenonah Campbell, and feedback from all co-authors.

Chapter 3. Making Connections between School and Home: Exploring Therapists' Perceptions of their Relationships with Families in Partnering for Change

This study was part of a large implementation and evaluation study completed in 2013-2015. Dr. Cheryl Missiuna, Prof. Nancy Pollock, Dr. Wenonah Campbell, Sandra Sahagian Whalen, and Leah Dix conceptualized and implemented the research project of which this study was a part. They developed the research protocol, applied for ethical approval, and organized data collection. Dr. Wenonah Campbell facilitated the focus groups that were used for data collection. I completed data analysis of the previously collected data, interpreted the findings and consulted the other authors as needed throughout this process. All authors contributed to the methodology of the project, and the analysis plan. I wrote all sections of the manuscript independently. All authors reviewed and edited the manuscript and approved the final version.

Chapter 4. The Dance of Family Engagement in School-based Occupational Therapy: An Interpretive Description

I conceptualized the idea for this study and developed the study's purpose and research question. With guidance from Dr. Wenonah Campbell, Dr. Cheryl Missiuna, Dr. Sandra Moll, and Dr. Jennifer Yost I chose the most appropriate research design to answer the research question. I completed ethics approval, recruitment, and all data collection. I led the data analysis and interpretation with co-coding assistance from Dr. Sarah Terreberry, and guidance from Dr. Wenonah Campbell. Finally, I prepared the manuscript, guided by Dr. Wenonah Campbell, and feedback from all co-authors.

Chapter 1. Introduction

An overview

Occupational therapists have the ecological view that children and their families are interconnected with each other, and the environments they live in (Jaffe, Humphry & Case-Smith, 2010). Families hold vital information regarding their child's interests, strengths, and needs, and they are typically the only constant in the child's life as they grow and participate in school and in their community (MacKean, Thurston, & Scott, 2005). Thus, engaging with families and following family-centred principles is considered best practice in providing individualized and meaningful care (Jaffe et al., 2010). Family-centred principles include: 1) acknowledging families as experts about their child and as essential members of the treatment team, 2) providing interventions tailored to families' individual characteristics and needs, and 3) designing interventions focused on supporting family functioning overall (e.g. Dunn, 2011; Dunst, Trivette, & Hamby, 2007; Rosenbaum, King, Law, King, & Evans, 1998). Beyond theoretical reasons for engaging with families, family-centred practice has been shown to improve child outcomes (Dunst, 2002; Morris & Taylor, 1998) and parent satisfaction with services (Law et al., 2003; O'Neil, Palisano, & Westcott, 2001; Van Siche, Siebes, Katelaar, & Vermeer, 2004). As a practicing occupational therapist for the last ten years, I understand the importance of collaborating with families to best support the children I work with. Unfortunately, the ability for a therapist to provide family-centred care relies heavily on their practice setting (Fingerhut et al., 2013).

In contrast to clinic-based services, when services take place in school settings the child is typically seen by the occupational therapist without their family present. This context presents a unique challenge for therapists in building relationships with families, providing family-centred care, and ensuring best practice (D'Arrigo, Copley, Poulsen & Ziviani, 2019; Fingerhut et al., 2013; Kennedy et al., 2020). Although the previous research on family engagement specific to school-based occupational therapy services is limited, some studies have explored family engagement in pediatric occupational therapy more generally and have included school-based occupational therapists in their studies (D'Arrigo et al., 2019; Fingerhut et al., 2013). This research highlights some of the contextually-related challenges that therapists face in family engagement (D'Arrigo et al., 2019), and concludes that school-based occupational therapists generally do not describe their practice as family-centered (Fingerhut et al., 2013). Thus, the available research is suggestive of a problem in how therapists engage families in the school setting but an in-depth analysis of the specific challenges is lacking.

My overall aim in this dissertation is to build on the breadth and depth of the currently available research by focusing solely on family engagement in the school context, and incorporating therapists' and families' voices to better understand family engagement from the perspectives of multiple stakeholders. To accomplish this, I explore family engagement in the unique nature of the educational context, contribute to the conceptual development of the term 'family engagement', provide an in-depth analysis of family engagement in school-based occupational therapy in Ontario, Canada, and generate stakeholder-informed solutions for occupational therapy practice.

Context of school health support services

Rehabilitation health professionals, including occupational therapists, physiotherapists and speech-language pathologists, have delivered school health support services in schools in Ontario since 1984 (Deloitte & Touche LLP, 2010). The purpose of providing services in the school setting, rather than a clinic setting, is to ensure that school-aged children are not denied access to education secondary to specific health needs (Deloitte & Touche LLP, 2010). Additionally, providing services in the school setting increases access to services for families with geographical or transportation barriers, and promotes inclusion by allowing children to remain in the school or classroom environment (Malatest & Associates Ltd., 2014; Missiuna et al., 2015). However, even though the purpose has been to promote access and inclusion, the approach to these healthcare services, provided in an education setting, has historically been aligned with a medical model, rather than a model that fosters inclusion, leading to inherent tension when working in the education setting.

The paradigm shift: Medical model approach to a collaborative service delivery model

In a medical model approach, rehabilitation health professionals focus on the child's impairments and provide direct therapy or recommendations to address these impairments and enhance their overall level of functioning. For example, an occupational therapist, speech-language pathologist, or physiotherapist may complete a standardized assessment on an individual child and then provide direct services to the child in a separate working space outside of the classroom to address the underlying issue. Given that school health support services were designed to meet the needs of children who have

complex medical needs it makes sense that a medical model approach was originally taken (Deloitte & Touche LLP, 2010). However, this approach limits the opportunities for effective knowledge transfer with other adults who support the child, and can impact the sustainability of recommendations that are implemented following completion of the services (Deloitte & Touche LLP, 2010). Moreover, communities have reported a broadening in the needs of children who are referred for school health support services; services are needed that focus on children's health and developmental needs more broadly in addition to serving children with multiple and complex needs (Deloitte & Touche LLP, 2010). A focus on providing direct therapy has meant lengthy waitlists for referred children, a primary focus on assessment to determine who qualifies for service, and limited opportunities for early intervention (Deloitte & Touche LLP, 2010; Hutton, 2009; Missiuna et al., 2012). In addition, removing a child from the classroom setting to engage in therapy is misaligned with the educational directive of ensuring inclusive education for all students (Campbell, Missiuna, Rivard, & Pollock, 2012).

For the reasons discussed above, therapists have witnessed a paradigm shift in how services are delivered in the school setting away from the traditional medical model approach towards an approach that focuses on collaborative consultation. A collaborative consultation approach promotes knowledge translation and capacity building with the intent that recommendations will carry over from year to year (Sayers, 2008). Rather than focusing on a child's deficits, this approach focuses on improving child participation and overall function through collaboration with educators and families (Campbell, Missiuna, Rivard, & Pollock, 2012). In support of this shift, research has shown that there are no

significant differences between child outcomes as a result of direct services compared to collaborative consultation services (Sayers, 2008). When collaborative consultation approaches are taken, however, teachers have reported increased satisfaction with services, and an increased likelihood of implementing recommendations within the classroom compared to the implementation of direct services (Sayers, 2008). Furthermore, collaborative consultation services are more congruent with educationally-based inclusion principles and, therefore, a continued shift to services that align better with the education setting is recommended (Malatest & Associates Ltd., 2014; Missiuna et al., 2015).

Unfortunately, this paradigmatic shift towards collaborative consultation services has been challenging for therapists to implement and many continue to deliver direct services instead of taking a more collaborative approach (Bayona et al., 2006; Spencer, Turkett, Vaughan, & Koenig, 2006). Several studies have looked at the barriers to implementation of collaborative consultation models, which Villeneuve (2009) outlined in a comprehensive review. These barriers include insufficient time for therapists and teachers to meet (Bayona et al., 2006; Bose & Hinojosa, 2008; Nochajski, 2001), inconsistent presence of therapists in the classroom (Nochajski, 2001), teachers' confusion about the role of occupational therapy services (Nochajski, 2001), and uncertainty about the roles and responsibilities within a collaborative partnership (Wehrmann, Teresa, Reid, & Sinclair, 2006). Less information is known about families' experiences of collaborative consultation services.

In response to the paradigm shift in service delivery and to address previously identified barriers, researchers at McMaster University developed a new service delivery model called Partnering for Change, where the therapist focuses on relationship building and knowledge translation with educators and families in the school context (Missiuna et al., 2012; Missiuna et al., 2017). Not only does this approach focus on ways to facilitate collaboration amongst educators, families and therapists, but it also allows for increased access to services for all children by embedding services in the classroom. By adopting an equity-focused service delivery approach rather than a traditional service pathway, Partnering for Change addresses many of the issues with school-based occupational therapy, including eliminating wait lists (Missiuna et al., 2015). This type of model is a tiered approach and is described in the next section.

Tiered services: Towards more innovative collaborative consultation models

In Partnering for Change and other similar tiered models, the first tier is a universal approach aimed at the whole classroom, or entire school (Missiuna et al., 2017). The first tier aims to foster inclusion and skill development in children of all abilities. At this level of service, the therapist observes the entire class and collaborates with the educator to make changes that will benefit all students. For example, the rehabilitation health professional and educator might collaboratively design learning environments that facilitate successful participation of all students. The delivery of services occurs in 'natural contexts', such as classrooms, hallways, gyms and playgrounds. Receiving services in these natural settings, rather than being pulled out of the classroom to work on

'therapy' is better aligned with the educational principles of inclusion (Campbell et al., 2012; Missiuna et al., 2017).

If some children continue to experience challenges following implementation of universal services, the therapist may decide that more targeted service (tier two) is required (Missiuna et al., 2017). If these targeted services still do not meet the needs of some children, then individualized interventions tailored to specific children (tier three) may be necessary. Consent for services is typically required at tier two, at which point family engagement in services is required. Throughout the tiers, successful strategies are shared with the educators that support children in the classroom. Successful strategies are shared with families to facilitate transfer of knowledge to the home setting, when appropriate. In addition to aligning well with current educational priorities that promote inclusive educational practices (Campbell et al., 2012), tiered approaches enable early identification of children, reduce wait times, and improve overall access to services (Missiuna et al., 2015).

The Partnering for Change service delivery model supports capacity building by fostering collaboration between occupational therapists and educators in the classroom as described above. A $1.2 million implementation and evaluation study, funded by Ontario's Ministry of Health and Long Term Care and the Ministry of Education, showed Partnering for Change to be a highly successful intervention (Missiuna et al., 2015). Results of this study indicated that Partnering for Change led to earlier identification of children with special needs, and increased educator capacity. The team observed, however, that even with such an improved model, it was still very difficult to engage with

families, despite families reporting a desire to be engaged (Missiuna et al., 2015). Chapter three of this dissertation explores therapists' perspectives in this study regarding family-therapist relationships.

Current status of occupational therapy in Ontario schools

The most recent published review of school health support services in Ontario was completed in 2010 to evaluate the program and identify strengths, weaknesses, and opportunities for improvement related to access and equity, and the coordination and quality of the service (Deloitte & Touche LLP, 2010). This in-depth review of school health support services was completed in response to a broader evaluation of community-based services in Ontario that highlighted issues related to fragmented care for children and families, and lengthy waitlists (Deloitte & Touche, 2010).

The Deloitte and Touche LLP (2010) review suggested that the school health support services program mandate was not clearly understood by all stakeholders and, therefore, the roles and responsibilities of all stakeholders were difficult to define. This review also outlined that most stakeholders felt the service scope and the legislation and policies guiding the service were outdated, and did not meet the needs of the students. Confusion around service mandate and outdated policies reportedly led to program inequities across the province (i.e., variability related to frequency of communication attempts with families). To address the concerns outlined by the review, the provincial government developed the Ontario Special Needs Strategy (Ministry of Child and Youth Services, 2016). This initiative aimed to develop a more coordinated and integrated

system for children and their families to receive timely and efficient services. Unfortunately, a change in government in 2018 ended the Special Needs Strategy meaning that services remain essentially unchanged.

Overall, the Deloitte and Touche LLP (2010) review highlighted substantial program related issues, and recommendations for future practice. Although services remain unchanged, the review is now quite dated and there is a need for future research related to occupational therapy in school health support services in Ontario.

Family engagement in school-based occupational therapy

Although family engagement is essential in pediatric occupational therapy practice, research suggests that family engagement in school-based occupational therapy services is more difficult to attain compared to clinic-based rehabilitation services because therapists do not routinely see families in person (D'Arrigo et al., 2019; Fingerhut et al., 2013). In a grounded theory study exploring family-centred care in pediatric occupational therapy, school-based occupational therapists described the involvement of the families they worked with at the level of an "informant" (Fingerhut et al., 2013, p. 233); essentially, the family is interviewed to obtain information about the child, but the involvement does not typically go further than this. School-based occupational therapists in this study were able to identify the benefits of a collaborative approach with families, but indicated they were limited by their practice context (i.e., not seeing the family when they see the child). Similarly, Deloitte and Touche's (2010) review of school health support services in Ontario identified that there is variability

between how frequently rehabilitation health professionals connect with families due to the lack of dedicated time and avenues for information exchange. Providers of school health support services "emphasize family engagement improves school health support service outcomes for their children;" however, "they often encounter challenges in determining optimal methods to reach parents" (Deloitte & Touche, 2010, p.10).

Due to the difficulties connecting with families, it is no surprise that families' level of engagement is typically only described as an 'informant.' Further research is required to explore the contextual factors influencing family engagement with greater depth and understanding.

Dissertation objectives

In summary, research and fundamental occupational therapy values suggest that family engagement is essential to services that take place in schools, but is very difficult to establish. Specifically, the unique context of the school cannot be ignored when exploring family engagement in these services. Due to the overall lack of family engagement research in this unique context, and the absence of the family voice in the literature that is available, I employ qualitative methods in this dissertation to achieve the following objectives:

1) **Describe and define family engagement** in the educational literature to improve school-based rehabilitation providers' understanding of this concept in this unique context, and to inform rehabilitation services that take place in schools rather than in typical rehabilitation contexts.

2) **Explore and describe how families and therapists engage with each other** in school-based occupational therapy services
3) **Identify and describe the factors that influence family engagement** from the perspectives of therapists and families.
4) **Develop stakeholder-informed solutions** to facilitate family engagement.
5) **Develop practice and policy recommendations** to help mitigate challenges and facilitate family engagement.

Interpretive framework and philosophical underpinnings

Researchers use interpretive frameworks and the philosophical assumptions that shape the framework to guide their research process. These philosophical assumptions and beliefs include *ontology, epistemology, axiology,* and *methodology* (Creswell, 2013).

Ontology refers to the nature of reality (Creswell, 2013). Qualitative researchers generally believe that multiple realities exist, rather than one single truth. As a result of this belief, qualitative researchers seek to report these multiple realities that are present in their participants' perspectives and experiences (Creswell, 2013).

Epistemology refers to how knowledge is known (Creswell, 2013). The qualitative researcher believes subjective evidence from participants counts as knowledge. Qualitative researchers use participant quotes as evidence of the new knowledge (Creswell, 2013). As a qualitative researcher, I believe that participants' subjective experiences count as valuable knowledge from which we can learn.

The *axiological* assumption in qualitative research is that research is value-laden, rather than value-free (Creswell, 2013). Instead of attempting to be completely objective, the researcher positions themselves within the study by acknowledging their values, assumptions, and biases as well as by actively reflecting on them throughout the research process for transparency purposes.

Methodology refers to the research process (Creswell, 2013). In qualitative research, there are a few characteristics that shape most qualitative inquiry, including the use of an inductive approach and an emergent design. All studies in this dissertation use inductive approaches and allow for flexibility in the research design. In particular, *Chapter Four* outlines an interpretive description study where all of these philosophical assumptions are highlighted.

As a researcher, I identify with the *social constructivist* interpretive framework. The *ontological* beliefs of this framework suggest that multiple realities exist and are formed through ones' experiences and interactions with others (Creswell, 2013). *Epistemological* assumptions include reality being co-constructed between the researcher and the participant and shaped by the researcher's and participant's individual experiences (Creswell, 2013). The *axiological* assumptions in this framework include research being value-laden, and values being negotiated amongst individuals (Creswell, 2013). Lastly, in terms of *methodology,* social constructivists tend to use inductive and emergent research methods. Throughout this dissertation, I have incorporated this social constructivist lens and followed the assumptions and philosophical underpinnings that shape this perspective.

Theoretical underpinnings

There is a gap related to guiding theoretical perspectives about family engagement from a rehabilitation lens and those that pertain to the unique context of school-based occupational therapy practices. Therefore, the theoretical underpinnings in this dissertation are largely borrowed from the educational literature. The work in this dissertation is theoretically guided by the theory of Overlapping Spheres of Influence (Epstein, 1987), Social Cognitive Theory (Bandura, 1986), and the Theoretical Model of Parental Involvement (Hoover-Dempsey & Sandler, 1995; Hoover-Dempsey & Sandler, 1997).

Overlapping Spheres of Influence

The theory of Overlapping Spheres of Influence (Epstein, 1987) was developed to demonstrate how interactions between the family and the school impact a child's development and learning. The theory consists of two spheres that represent the family and the school. How much the spheres overlap depends on three forces acting on the spheres: (1) time; (2) characteristics, philosophies, and practices of the family; and (3) characteristics, philosophies, and practices of the school. When parents participate in their child's learning, the spheres have greater overlap. Similarly, when teachers enable parental involvement in school, there is greater overlap between the spheres. The notion of reciprocity between schools and families is a central feature of this model. The extent of overlap is maximized when schools and families partner with each other and participate in shared activities.

Regarding family engagement in school-based occupational therapy practices, Epstein's (1987) theory demonstrates the importance of all 'spheres' that influence a child's overall development. In addition to the family and school spheres, it is likely that the occupational therapist brings an additional sphere of influence to the child's overall experience. The forces acting on the spheres (i.e., time, characteristics of the family and school) are pondered throughout this dissertation when considering the factors that shape the nature of family engagement.

Social Cognitive Theory

Social Cognitive Theory is one of many theories that can enhance researchers' understanding of human behaviour (Bandura, 1986). Social Cognitive Theory proposes that learning occurs in a social context within a *triadic reciprocal* relationship between personal and cognitive factors, behaviour, and environmental influences (Bandura, 1986). The triadic reciprocal relationship includes many constructs that claim to shape how learning occurs (McAlister, Perry, & Parcel, 2008). For example, *reciprocal determinism* is a construct that describes how the environment influences people, but how people can also influence the environment and regulate their own behaviour (McAlister et al., 2008). Another example is, *outcome expectations*, which suggests that individuals' beliefs about the outcome of their behavioural choices influence the behaviours in which they engage (McAlister et al., 2008). Overall, there are nine different constructs identified that influence the triadic reciprocal relationship, and ultimately, how an individual behaves and learns.

The underlying principles of Social Cognitive Theory are utilized in this dissertation to better understand the personal, behavioural, and environmental interactions and outcomes pertaining to each individual who has a role in school-based occupational therapy services. In particular, the school environment and the personal factors for each family member, occupational therapist, and educator help determine how the *behaviour* (i.e., engagement) is created and sustained.

Theoretical Model of Parental Involvement

Stemming from Social Cognitive Theory, the Theoretical Model of Parental Involvement seeks to explain the reasons parents become involved in their children's education and the outcomes of their involvement (Hoover-Dempsey & Sandler, 1995; Hoover-Dempsey & Sandler, 1997). A revised Theoretical Model of Parental Involvement focuses on what influences parents' decisions to become involved, and the types of parental involvement (Walker, Wilkins, Dallaire, Sandler & Hoover-Dempsey, 2005). The first level in the revised model includes all of the factors that lead to parental involvement including: parents' motivational beliefs, parents' perceptions of invitations for involvement from others, and parents' perceived life context (Walker et al., 2005). The first component in that level, *parents' motivational beliefs*, is further broken down into *parental role construction* and *parental self-efficacy*. Parental role construction is parents' beliefs about how they should be involved in their child's schooling. Parental self-efficacy refers to parents' beliefs about their capability to be involved in their child's education. Both role construction and self-efficacy are linked to personal and cognitive factors in Social Cognitive Theory and influence behaviour (Hoover-Dempsey & Sandler,

1995). The revised Theoretical Model of Parental Involvement suggests parents who believe their role is important, and parents who feel they have the capacity to be involved, are more likely to participate in their child's education than parents who do not (Walker et al., 2005).

The second component of the first level of the revised Theoretical Model of Parental Involvement is *parents' perceptions of invitations for involvement from others*. This factor refers to parents' views regarding how the school staff, teacher, and child feel about having them involved in the education process. The model suggests that parents who feel welcomed by the school staff, educator, and their child are more likely to become involved (Walker et al., 2005).

The final component of the first level of the revised Theoretical Model of Parental Involvement is *parents' perceived life context*. This includes parents' *skills and knowledge* and *time and energy.* Skills and knowledge refer to the parents' actual competence to perform the required tasks with their children. This construct is viewed as a personal and cognitive factor of Social Cognitive Theory. Time and energy are aligned with the environmental factors of the Social Cognitive Theory as they refer to parents' perceptions of their available time and energy, and resources to overcome any barriers. The authors of the revised Theoretical Model of Parental Involvement suggest that, if parents have the appropriate skills and knowledge and feel they have the time and energy to become involved in their children's education, they are more likely to do so (Walker et al., 2005).

According to the model, all the factors described above impact the type of *parental involvement forms* that parents assume (Walker et al., 2005). The second level of the revised Theoretical Model of Parental Involvement outlines two types of parental involvement forms, including *home involvement* and *school involvement*. Examples of home involvement include supervising the child's homework, practicing spelling, math or reading, and helping the child study (Walker et al., 2005). School involvement refers to activities such as attending open houses or special events at the school, volunteering, or attending parent-teacher conferences (Walker et al., 2005). Although focused in education, it is evident that elements of this theoretical model may be relevant to family engagement in school-based occupational therapy services. Both the factors that influence families' actions (level 1), and the types of actions families take (level 2) could be relevant. In this dissertation, I utilize the model to inform my understanding of the factors that may influence the different ways that families engage in their child's occupational therapy services that take place in the school.

Summary of dissertation chapters

There are five chapters contained in this work that together provide readers with a multi-stakeholder exploration of family engagement in the unique context of school-based rehabilitation. In the following paragraphs, I outline the contents of each chapter that comprise the overall dissertation. Additionally, I address any overlap that may exist between these chapters regarding background literature or methodology.

In this chapter, *Chapter One,* I presented an overview of family engagement in school-based occupational therapy services, provide context around the history of school health support services, and present various service delivery models implemented within this service. Additionally, I highlighted the current status of family engagement within services that take place in schools and the major gaps in the available research. Some of the literature that I presented in this chapter specific to family engagement in school-based occupational therapy services is explored in greater depth in *Chapters Two* and *Four.* Tiered models of service delivery, specifically the Partnering for Change model, were presented in *Chapter One* but discussed in greater detail in *Chapter Three*.

Chapter Two depicts a concept analysis that critically analyzes the concept of family engagement as discussed and studied in the education literature. I conceived the idea for this paper upon reading the current literature related to family engagement from various pediatric healthcare settings (D'Arrigo et al., 2019; King, Currie, & Peterson, 2014). The researchers who have focused on this topic primarily investigate family engagement in settings where the family brings the child to the service location (e.g., clinic-based settings), which I suspected may not be reflective of family engagement in settings where the family is not present. Instead, I wondered whether more insight might be gained for school-based therapists by researching family engagement in educational contexts. I explored and evaluated the maturity of this concept by analyzing and summarizing the literature in terms of the conceptual definition, preconditions, boundaries, and outcomes. My analysis shows that this concept is still emerging and further concept development is required; however, I suggest many implications for

professionals working with families and children in educational settings, including a proposed definition to contribute to further concept development. Overall, I conclude that, until research is available specific to rehabilitation services that take place in educational settings, school-based therapists can use the findings in this study to consider the many preconditions that support family engagement in the school context, and the actions they could take to meet the individual needs of each family.

In *Chapter Three,* I present a qualitative description study exploring occupational therapists' experiences of the family-therapist relationship using the Partnering for Change service delivery model. The purpose of this study was to describe the factors that therapists view as influencing the development of family-therapist relationships in this unique service delivery model and to explore their ideas to improve relationship-building. Through analysis of focus group data, I identified several factors influencing family-therapist relationships in this unique service delivery model. Factors included: 1) therapists' and families' competing demands (e.g., time); 2) consistency of the service and the availability of therapists; 3) families' awareness of services, families' and therapists' readiness to participate in services, and families' commitment to services; 4) relationships with schools and educators; and 5) sociodemographic factors (e.g., languages spoken). The occupational therapists in this study provided suggestions for improving family-therapist relationships including increasing opportunities for face-to-face interactions, and increasing families' awareness of their services. Overall, I recommend that therapists working in this model should consider ways of overcoming competing demands, utilize their strong relationships with educators and schools, and

participate in communities of practice to address current barriers and improve relationships with families. I also highlight the need for further research that includes the family voice to gain a better understanding of factors that influence the family-therapist relationship, and family-informed strategies for improvement. As detailed below, I use a broadened lens in *Chapter Four* by interviewing both therapists, and families, and not limiting the discussion about family engagement to one type of service delivery model.

Chapter Four presents an interpretive description study exploring family engagement in school-based occupational therapy services from the perspectives of both occupational therapists and families. The purpose of this study was to explore the ways families and occupational therapists engage with each other, what influences their engagement, and strategies to support engagement in school-based occupational therapy services in Ontario. Semi-structured, one-to-one interviews were the primary means of data collection. As a result of the analysis, I offer an interpretation that family engagement in school-based occupational therapy services is like a group dance where the dancers, choreography, and music represent important elements of family engagement. I also outline stakeholder-informed solutions and strategies for the betterment of this service. I discuss three key messages resulting from my analysis: 1) Family engagement is defined by the actions of the entire team, rather than just those of the family; 2) Family engagement depends on stakeholders' overall capabilities and resources; stakeholder roles should be negotiated based on families' individualized needs and preferences; and 3) There are substantial service factors that hinder family engagement. Major shifts in service delivery are required to increase the value families place on school-based

occupational therapy services. In conclusion, I recommend a major service transformation to improve family-therapist relationships as well as to increase the value of school-based occupational therapy services for children and their families.

In the final chapter, *Chapter Five*, I highlight the main messages related to this dissertation from the previous chapters. I propose a new definition of family engagement specific to school-based rehabilitation. I also propose The Model of Family Engagement in School-Based Rehabilitation by adapting the revised Theoretical Model of Parental Involvement (Walker et al., 2005) and the theory of Overlapping Spheres (Epstein, 1987), and by incorporating the findings in this dissertation to inform school-based practice, and family engagement in rehabilitation more broadly. Lastly, I discuss the overarching contributions of this work and outline the resulting practice and policy implications.

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Chapter 2. The concept of family engagement in education: What are the implications for school-based rehabilitation service providers?

This chapter presents a concept analysis of 'family engagement' in the educational literature and outlines the implications for rehabilitation service providers who work in school settings.

Prepared for submission to: International Journal of Disability, Development and Education

The concept of family engagement in education: What are the implications for school-based rehabilitation service providers?

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The concept of family engagement in education: What are the implications for school-based rehabilitation service providers?

Abstract

Introduction: The concept of family engagement within the rehabilitation literature focuses on clinic-based therapy sessions and is not particularly relevant to therapists working in school settings. In this study, we explored the concept of family engagement as represented in the education literature to provide school-based therapists with a better understanding of this concept in the school context. **Methods:** We applied scoping review methods for the literature search and screening process, and utilized concept evaluation methodology for our analysis of included articles. Specifically, we examined concept evaluation components, including definition, characteristics, boundaries, preconditions, and outcomes. **Results:** We did not find a clear definition of family engagement in the extant literature; however, there were some common characteristics. Our analysis of boundaries indicated family engagement and parent involvement are not synonymous but are closely linked. We also identified several preconditions for family engagement in education, including: an inviting and inclusive school culture; a broad understanding of engagement; positive educator-family relationships; and families' confidence, beliefs, and supportive life contexts. Associated outcomes included academic achievement, high school completion, and child social-emotional functioning. **Conclusions:** We proposed a broad definition based on our analysis of the included articles. Adopting a broad definition of family engagement is important for educators and school-based therapists to ensure families feel their efforts are meaningful. Educators and school-based therapists

should consider their actions in supporting the individual needs of families, and the identified preconditions that support family engagement.

Keywords

family engagement, education, school-based health services, rehabilitation, concept evaluation, family-therapist relationships

Introduction

School-based rehabilitation services (SBRS) such as occupational therapy, speech-language pathology, and physiotherapy, are provided in school settings to promote successful inclusion and performance of students with a variety of needs (Deloitte & Touche, 2010). A recent scoping review on SBRS highlights the various ways these services are delivered, and suggests that SBRS focus on collaborating with all adults present in a child's environment (Anaby et al., 2018). The importance of engaging the family in SBRS was a key message in this review (Anaby et al., 2018). However, there is limited research available to guide school-based rehabilitation providers (SBRP) in promoting family engagement in SBRS, and the literature that is available suggests it is difficult to achieve (D'Arrigo, Copley, Poulsen, & Ziviani, 2019; Fingerhut et al., 2013; Kennedy et al., 2020; Missiuna et al., 2015).

SBRS are unique as they take place in the school and primarily occur during school hours, without a family member present. This contrasts with clinic-based rehabilitation services where family accompany the child to the appointment, thus allowing for interaction and rapport building (D'Arrigo et al., 2019). Opportunities for face-to-face connection and relationship building are not inherent to SBRS, which creates additional barriers to family engagement (D'Arrigo et al., 2019). Moreover, when working in schools, SBRP have noted that they prioritize relationship building with educators, rather than parents, due to large caseloads and time constraints (D'Arrigo et al., 2019; Kennedy et al., 2020). These factors, amongst others, contribute to the difficult nature of engaging with families in SBRS.

Literature Review

Although there is limited research in family engagement specific to SBRS, three studies explore engagement in various pediatric healthcare settings (D'Arrigo et al., 2019; King, Currie, & Peterson, 2014; King et al., 2020). Each study and its interpretation of engagement (family engagement, or child and parent engagement together) is discussed below.

Two of the identified studies discuss engagement in similar ways. These studies include: a scoping review of mental health literature to better understand the indicators of child and parent engagement within treatment sessions (King et al., 2014), and a qualitative study exploring the nature of 'in-therapy' engagement in clinic-based pediatric rehabilitation from the perspectives of youth, caregivers, and service providers (King et al., 2020). Both studies describe engagement as a complex construct involving three domains connected to the therapy process: affective, behavioural, and cognitive (King et al., 2014; King et al., 2020).

The affective domain is determined by the relationship with the therapist, where the child and parent may exhibit positive attitudes, enthusiasm, interest, and contentment if they are engaged (King et al., 2014). The behavioural domain is exhibited by the child's or parent's perception of self-efficacy, portrayed by in-session behaviour such as asking questions, sharing thoughts, making eye contact, and displaying positive body language (King et al., 2014). Additionally, being cognitively engaged is demonstrated by a child's or parent's effort, sense of readiness for change, and understanding or acknowledging that a problem exists (King et al., 2014). Overall, there are many factors that suggest whether

a child or parent is engaged in service provision; however, there are limitations with how these conceptualizations of engagement can be applied to SBRS when families are not present during service visits.

The qualitative study exploring youth, caregiver, and service provider perspectives of engagement also endorsed the affective, cognitive, and behavioural domains, but included additional themes that were specific to in-person therapy sessions taking place in a pediatric rehabilitation clinic (King et al., 2020). The findings indicated engagement was viewed as: 1) connection (a personal connection with the service provider, the therapy goal or vision, or the therapy activity); 2) working together (engagement through clear and open conversation and collaboration, receiving a message of worth, working together to achieve goals); and 3) an affective and motivational process (an experiential process, an associated affect, and personal motivation) (King et al., 2020). Overall, this study focused on engagement related to in-person therapy sessions and did not focus on family engagement specifically; rather, the authors explored the therapeutic process more generally by comparing perspectives of engagement from youth, caregivers, and service providers. This study provides important information about engagement in pediatric rehabilitation, but again, may not be relevant to SBRS.

In the school setting, where the parent typically is not present, SBRP are unable to analyze a parent's behaviour to determine whether they are engaged or not (e.g., eye contact, body language, contributions to the sessions, etc.). Therefore, it is likely that some of the indicators of parent engagement in a school setting will be different than the indicators reported in clinic-based settings. This notion is supported by an interpretive

description study exploring family engagement in occupational therapy services across a variety of pediatric settings, including the perspectives of some therapists who work in schools (D'Arrigo et al., 2019). D'Arrigo and colleagues suggested that family engagement was evident through a range of family behaviours including full participation in therapy; being responsive to the therapist and the therapy process (i.e., demonstrating enthusiasm); and communicating with the therapist. However, the therapists in this study reported that family engagement is not always explicit and can be difficult to assess, particularly when parents are not present at the session, such as in the school setting (D'Arrigo et al., 2019).

The literature on family engagement in pediatric healthcare settings indicates that behavioural aspects are most easily assessed while in the presence of the family member (D'Arrigo et al., 2019; King et al., 2014; King et al., 2020), and since face-to-face interactions with families are not typical in school settings, SBRP have limited guidance in understanding and promoting family engagement. Further research is required to enhance family engagement and promote family-centred care in services delivered in the school setting; but first, what it means for families to be engaged in SBRS needs to be considered and explored.

To understand family engagement in rehabilitation services that occur in the school setting, it may be more relevant to consider the concept of engagement as described in the education literature. Specifically, what does family engagement mean in a child's education? Although family engagement in SBRS may not be synonymous to family engagement in education, the two contexts are very similar: Parents typically are

not physically present in either situation, meaning they might experience similar barriers to engagement. These similarities suggest that parents' engagement in their children's schooling broadly may be more relevant to understanding how parents engage in their children's SBRS than comparisons with how parents engage in clinic-based rehabilitation. Uncovering how parent engagement is conceptualized in the education literature is the first step to exploring ways SBRP might better understand and facilitate parent engagement in SBRS.

In this study, we will develop a broad conceptualization of family engagement as represented in the education literature, thereby enhancing how family engagement might be understood in SBRS. We posed the following research question: How is family engagement defined, described, or conceptualized within the education-based scholarly literature? Our discussion will focus on how this conceptualization may inform family engagement in SBRS.

Methods

We employed concept evaluation methodology (Morse, Mitcham, Hupcey, & Cerda Tasón, 1996), which is an approach for determining how well a concept is defined in scholarly literature and its overall maturity in a field. Table 1 describes the five concept evaluation components and the corresponding indicators of concept maturity. Exploring the concept in this way helps to identify the usefulness of the concept for clinical practice and/or research (Morse et al., 1996).

< insert table 1 about here>

Although concept evaluation methodology has well-described procedures for concept exploration, it does not offer guidance on how to search for and compile pertinent literature. Consequently, we chose to follow scoping review methodology to ensure a systematic approach. We utilized Arksey and O'Malley's (2005) methodological framework for scoping reviews to locate relevant studies and select articles for inclusion. Consultation with a librarian from McMaster University informed the development of a comprehensive search strategy. Two major concepts in the research question were identified and defined: parent/family engagement and school/education. Alternative terms and appropriate subject headings were used to broaden the search (See Table 2). We then applied our search strategy to literature published between 2000 and 2018 in the ERIC and PsychINFO electronic databases. We searched terms for each concept independently and then combined with the OR Boolean term. The results from each concept were then combined using the AND Boolean term. The search yielded 7112 articles. The flow diagram in Figure 1 illustrates the search yield and screening process.

< insert Table 2 about here>

<insert Figure 1 about here>

Next, we uploaded all citations to Endnote X7 (2013) reference management software and then exported into Covidence (2016), an online software that organizes the documents and the screening and selection process. Fifteen percent of the articles were randomly selected and assigned for title and abstract review by two independent reviewers (J.K., V.T.) to determine interrater reliability ($\kappa = 0.78$). Following the reliability sample, the two reviewers continued reviewing independently until all articles

were screened. When it was unclear if the article met inclusion criteria, the reviewers met to discuss the article and came to consensus on whether it should be included or not. An inclusion decision tree was developed iteratively throughout the title and abstract screening process and was finalized prior to the full-text screening stage (see Figure 2). The two reviewers completed another interrater reliability sample at the full-text stage, resulting in a strong level of agreement ($\kappa = 0.81$), prior to moving to independent review (McHugh, 2012). Once the screening process had concluded, the researchers uploaded the included articles to QSR International's NVivo 11 (2015) software to collate and code the data.

<insert Figure 2 about here>

The first author (J.K.) used concept evaluation methodology (Morse et al., 1996) to guide the development of the preliminary codebook and the overall analysis of the included data. Some codes were deductive in nature (i.e., definition, boundaries), while others were added to the codebook inductively through review of the included literature (i.e., relationships, trust, power). Once developed, two coders (J.K., S.T.) independently applied the preliminary codebook to two of the included articles. Following this process, the two coders discussed code meanings, definitions and interpretations, and how the codebook could be amended and finalized before applying widely. After the coding process, the first author studied linkages and commonalities between articles, and evaluated each domain of the concept (definition, characteristics, boundaries, preconditions, and outcomes). The findings outline the common themes, and evaluate the concept's maturity within each of the concept evaluation domains.

Results

Seventeen articles met inclusion criteria and were included in this concept analysis. Most originated in the United States (n=11). Other counties of origin included England (n=2), Australia (n=1), Canada (n =1), New Zealand (n=1), and Scotland (n=1). Fifteen of the seventeen articles were published within the last 10 years. The included articles were all scholarly in nature and included empirical studies (n=12), literature reviews (n=2), theoretical papers (n=2), and an executive summary of a group of research reports. Family or parent engagement is described or defined in all seventeen documents. For each article, Table 3 summarizes the type of article, study purpose, and definition/description of parent/family engagement.

<insert Table 3 about here>

Definition and characteristics

After reviewing the included articles, it was evident that there was an absence of a singular shared definition in the literature. The various definitions and descriptions of family engagement extracted from the literature are presented in Table 3. Although there are many ways family engagement is defined in the literature, there was some consistency noted regarding the characteristics associated with this concept. The characteristics of family engagement that were consistently cited across the articles described the concept as: ***a multi-faceted term*** *used to describe families' and educators' attitudes and actions towards children's education; shaped by the* ***individualized needs of the family, their culture and their past experiences; a dynamic process*** *that families and educators/schools participate in to support children's learning; characterized by*

reciprocal relationships *between families and educators; encompassing* ***communication, collaboration, shared power, and mutual responsibility*** *for child outcomes; and taking place across* ***multiple environments****.*

Even though the included articles lacked a consistently used definition of family engagement, the main characteristics of the concept were commonly described across the articles. However, according to concept evaluation methodology, the lack of a commonly used definition, and overall variability in terms of conceptualization, indicates the concept is still emerging and establishing maturity despite some commonly cited characteristics.

Boundaries

Family engagement has bordering concepts such as *parent participation* and *family-school partnerships* (McKenna & Millen, 2013; Sime & Sheridan, 2014; Warren et al., 2009); however, one concept featured prominently in the literature was *parent involvement*. Many articles discussed the differences between family engagement and parent involvement (Barton et al., 2004; Carréon et al., 2005; Greenberg, 2012; Ishimaru et al., 2016; Jensen & Minke, 2018; McKenna & Millen, 2013; Naqvi et al., 2015, Posey-Maddox, 2017a, 2017b; Sime & Sheridan, 2014; Warren et al., 2009; Watt, 2016). Some articles suggested that family engagement is connected to parent involvement either along a continuum with family engagement building on parent involvement (Goodall & Montgomery, 2014; Warren et al., 2009), or as an umbrella term that incorporates parent involvement (Barr & Saltmarsh; Warren et al., 2009). Despite many efforts to outline the boundaries between these concepts, they are often used interchangeably in the literature making it difficult to know what authors are referring to when they use these two terms

(Jensen & Minke, 2018; Naqvi et al., 2015). It is clear from the literature that these are distinct concepts; however, they do share some features, which has contributed to confusion in the field.

Features of parent involvement

The literature included in this review suggested that parent involvement is what parents do, or more specifically, their actions related to activities that are proposed by the school (Barton et al., 2004; Sime & Sheridan, 2014; Warren et al., 2009; Watt, 2016). Some examples of parent involvement in the literature include communicating with teachers, checking homework, attendance at school events, fundraising, and volunteering (Jensen & Minke, 2018; McKenna & Millen, 2013; Watt, 2016). The school decides what is expected from the parents and parents are seen as passive participants who help the teacher with specific tasks or activities (Jensen & Minke, 2018, Posey-Maddox, 2017a, 2017b, Ishimaru et al., 2016; Goodall & Montgomery, 2014; Warren et al., 2009). Furthermore, parent involvement is historically recognized as a strategy for helping underperforming children by having their parents more involved with the school (Ishimaru et al., 2016). This strategy stemmed from the idea that the causes of underperformance were a result of issues at home, and increasing parents' involvement in the school would assist with student success (Ishimaru el al., 2016). This deficit lens does not consider social factors (i.e., language barriers, lack of personal education, lack of transportation, inflexible work schedules) that impact a parent's ability to participate in the school-sanctioned activities (Carréon et al., 2005; Goodall & Montgomery, 2014; Greenberg, 2012).

In parent involvement, school staff are in control of the relationship and flow of information with parents, and the school instigates the activities that the parents can participate in, most of which happen on school property (Goodall & Montgomery, 2014; Watt, 2016). The communication tends to be unidirectional from educators to parents (Naqvi et al., 2015). Unfortunately, an educator's understanding of a parent's level of involvement is based on the parent's participation in school-centric activities and their visible behaviours in the school (Jensen & Minke, 2018). Thus, parents who are unable to take part in school-sanctioned activities are deemed to be parents with low levels of involvement (Posey-Maddox, 2017a, 2017b). Overall, when the focus is parent involvement, there are limited opportunities for parents to participate in ways that move beyond school-centric communication or activities (Ishimaru et al., 2016).

Relationship between family engagement and parent involvement

The literature included in this study proposed that family engagement can incorporate aspects of parent involvement (Barr & Saltmarsh, 2014; Jensen & Minke, 2018; Liu & White, 2017; Warren et al., 2009). Family engagement was described as an umbrella term that not only encompasses parental involvement (Warren et al., 2009; Liu & White, 2017), but also parental participation and family-school partnerships (Barr & Saltmarsh, 2014; Jensen & Minke, 2018). Similarly, it was suggested these terms should be placed on a continuum with parent involvement with the school as the starting point, and family engagement with the child's learning as the ultimate goal (Goodall & Montgomery, 2014).

Although the reviewed literature provided some clarity around parent involvement and family engagement concepts, there is still much that contributes to the ambiguity between these two terms. For instance, of the 321 articles included in the full-text review, 44 were eliminated because they did not distinguish between these two concepts and their inclusion would have led to further ambiguity. It is important to acknowledge this substantial finding as this demonstrates family engagement is still emerging as a mature, distinct concept in terms of boundaries and bordering concepts.

Preconditions

Several examples of preconditions that help to foster family engagement were identified, including: an inviting and inclusive school culture (Barr & Saltmarsh, 2014; Carréon et al., 2005; Greenberg, 2012; Ishimaru et al., 2016; Mutch & Collins, 2012; Naqvi et al., 2015; Sime & Sheridan, 2014); a broad understanding of engagement (Baker, Wise, Kelley, & Skiba, 2016; Barton et al., 2004; Carréon et al., 2005; Greenberg, 2012; Goodall & Montgomery, 2014; Ishimaru et al, 2016; Jensen & Minke, 2018; McKenna & Millen, 2013; Posey-Maddox, 2017a; Posey-Maddox, 2017b; Sime & Sheridan, 2014; Warren et al., 2009); educator-family relationships encompassing trust, communication, and shared power (Barr & Saltmarsh, 2014; Carréon et al., 2005; Goodall & Montgomery, 2014; Ishimaru et al., 2016; Jensen & Minke, 2018; McKenna & Millen, 2013; Mutch & Collins, 2012; Sime & Sheridan, 2014; Warren et al., 2009); and families' confidence, beliefs about engagement, and supportive life contexts (Baker et al., 2016; Barton et al., 2004; Carréon et al., 2005; Goodall & Montgomery, 2014; Greenberg, 2012; Ishimaru et al., 2016; Sime & Sheridan, 2014; Watt, 2016). The identified

preconditions were not present in every included article, as would be the case with more mature concepts, but they were discussed in many of the included articles. Given that the characteristics and definition of family engagement are still in the emerging phase of concept development, the preconditions examined in this review are emerging as well.

An inviting, inclusive school culture and broad understanding of engagement

Based on analysis of the included literature, a precondition to family engagement is a school that values inclusivity, ensures a welcoming environment, and holds a broad conceptualization of engagement. Many studies noted these factors to be essential to supporting family engagement, especially for school communities that include families from diverse cultures and ethnicities, or families from marginalized populations (Barr & Saltmarsh, 2014; Carréon, Gustavo Perez, Drake, & Barton, 2005; Greenberg, 2012; Ishimaru et al., 2016; Mutch & Collins, 2012; Naqvi, Carey, Cummins, & Altidor-Brooks, 2015; Sime & Sheridan, 2014).

An inviting, inclusive school culture. The literature examined in this study suggested that the overall school culture has an important role in supporting family engagement. Moreover, the principal has a particularly important role in setting the tone and creating an inclusive and welcoming school culture (Barr & Saltmarsh, 2014; Greenberg, 2012; Mutch & Collins, 2012; Sime & Sheridan, 2014). The principal's formal management techniques, personal values, and personality attributes are highly influential in determining the overall school culture (Barr & Saltmarsh, 2014). Families' comfort and satisfaction with the school is related to the comfort and satisfaction they feel with school administration (Greenberg, 2012; Ishimaru et al., 2016). As a result, families

either feel welcomed, or unwelcomed, based on the principal's inclusion efforts (Barr & Saltmarsh, 2014; Greenberg, 2012; Mutch & Collins, 2012; Sime & Sheridan, 2014).

The authors of one included study suggested that principals substantially influence whether teachers embrace the broader community or not (Barr & Saltmarsh, 2014). When principals challenge teachers' deficit views of the surrounding community, and families within that community, teachers are more likely to foster inclusive mindsets and embrace diversity (Barr & Saltmarsh, 2014). This leads to families feeling welcomed, safe, and understood; as a result, families are more likely to build relationships with the educators and administrative staff (Barr & Saltmarsh, 2014). For immigrant families who have recently moved to a new country, a lack of familiarity with the education system, as well as cultural and language barriers, may contribute to family disengagement (Carréon et al., 2005; Greenberg, 2012; Ishimaru et al., 2016; Naqvi et al., 2015). Instead of assuming families do not want to engage or are incapable of doing so, several authors suggested that schools provide support navigating the education system and include cultural practices that reflect those in their surrounding communities to help make families feel welcomed, safe, and supported (Carréon et al., 2005; Greenberg, 2012; Ishimaru et al., 2016; Naqvi et al., 2015). Overall, the literature indicates that these efforts must be encouraged and prioritized by the principal to promote an inclusive, welcoming climate amongst all school staff.

Broad understanding of engagement. Families reportedly engage in their children's learning in many ways other than having a physical presence in the school; however, this is not represented in education's traditional view of engagement (Baker et

al., 2016). The traditional interpretation of engagement is typically measured in studies by a families' presence in the school and participation in 'school-centric' activities, which are those that are visible to educators, such as volunteering and attending meetings at the school (Jensen & Minke, 2018). Educators' limited understanding of engagement promotes deficit-based views of families being unable to engage due to their difficulties communicating with educators (Carréon et al., 2005), inflexible work schedules (Greenberg, 2012), and inability to afford or obtain transportation or child care to attend school-centric meetings (Baker et al., 2016). Families are then considered 'low engagers' by educators based on their inability to engage in traditional, school-centric ways (Carréon et al., 2005; McKenna & Millen, 2013).

Many articles reported that part of ensuring an inclusive school climate is having a broad understanding of engagement that encompasses a range of activities with which families from diverse backgrounds can engage (Baker et al., 2016; Barton et al., 2004; Carréon et al., 2005; Greenberg, 2012; Goodall & Montgomery, 2014; Ishimaru et al, 2016; McKenna & Millen, 2013; Posey-Maddox, 2017a; Posey-Maddox, 2017b; Sime & Sheridan, 2014; Warren et al., 2009). When educators believe that engagement can take multiple forms, families' efforts that are focused on supporting their child's learning at home, and in the community, are celebrated and encouraged (McKenna & Millen, 2013; Posey-Maddox, 2017a; Posey-Maddox, 2017b). Having a broad understanding of this construct, rather than a traditional, school-centric view, allows families who engage in non-traditional ways to feel welcomed and respected in the school, and endorses ongoing engagement.

Educator-family relationships encompassing trust, communication and shared power

The importance of establishing strong educator-family relationships is commonly discussed in the literature and appears to be another precondition of family engagement. To promote family engagement, educators' emphasis should be placed on forming non-judgmental, supportive relationships with families, rather than focusing on the activities in which families do, or do not, participate (Goodall & Montgomery, 2014). Features that are essential to establishing strong relationships between educators and families include: having a sense of trust (Barr & Saltmarsh, 2014; Carréon et al., 2005; Goodall & Montgomery, 2014; Ishimaru et al., 2016; Mutch & Collins, 2012; Warren et al., 2009), having frequent and clear communication (Carréon et al., 2005; Ishimaru et al., 2016; McKenna & Millen, 2013; Mutch & Collins, 2012; Sime & Sheridan, 2014; Watt, 2016), and sharing power (Carréon et al., 2005; McKenna & Millen, 2013; Naqvi et al., 2015; Posey-Maddox, 2017b; Sime & Sheridan, 2014; Warren et al., 2009).

Trust. The literature indicated that mutual trust and respect between families and educators is of utmost importance for establishing strong relationships. In particular, having a relationship with at least one educator is deemed to be important in promoting family engagement by building a sense of trust between the family and the school (Carréon et al., 2005). Establishing strong relationships and trust can be difficult if the educators and families are from different cultures, and speak different languages (Ishimaru et al., 2016). Many authors suggested strategies that bridge these gaps as an essential first step to building trust and establishing relationships, and promoting family

engagement (Barr & Saltmarsh, 2014; Carréon et al., 2005; Goodall & Montgomery, 2014; Ishimaru et al., 2016; Mutch & Collins, 2012; Warren et al., 2009).

Communication. Clear communication is deemed a necessity to developing and maintaining relationships between educators and families (Carréon et al., 2005; Ishimaru et al., 2016; McKenna & Millen, 2013; Mutch & Collins, 2012; Sime & Sheridan, 2014; Watt, 2016). Communication efforts by educators need to be understandable and culturally inclusive (Ishimaru et al., 2016). Translation or translators need to be made available when necessary; otherwise, parents may feel excluded and inferior (Carréon et al., 2005). Educators should be provided with resources and support to assist them with reducing barriers to communication, when possible, by ensuring the language they are using is accessible and jargon-free (Watt, 2016).

The literature also reports that communication needs to be frequent (Mutch & Collins, 2012; Watt, 2016) and bi-directional, rather than always from educator to family (Barr & Saltmarsh, 2014; McKenna & Millen, 2013; Warren et al., 2009). Families need to be able to communicate with educators if they need to rather than waiting for the educators to connect with them. Bi-directional communication allows families to ask questions and clarify information to ensure they can best support their child rather than always waiting to hear from the educator first. Multiple authors recommended that educators make themselves available to families to ensure two-way communication is possible (Barr & Saltmarsh, 2014; McKenna & Millen, 2013; Warren et al., 2009).

Additionally, educators need to make consistent efforts to update families on their child's progress (Mutch & Collins, 2012; Watt, 2016). Outside of traditional

communication opportunities, such as parent-teacher conferences, families often only receive information when their child is having difficulties at school (Baker et al., 2016). Instead, educators should provide frequent communication and updates on their child's progress and allow for opportunities for families to share information beyond parent-teacher conferences (Mutch & Collins, 2012; Watt, 2016).

Overall, authors of included studies emphasize that communication needs to be clear and accessible, bi-directional, and consistent to promote and support family engagement. Additionally, educators and school administrators need to ensure translation and translators are available to prevent barriers and promote inclusivity.

Power. In traditional models of educational power, the teacher knows best and is considered the expert (Warren et al., 2009); however, the importance of power sharing between educators and families is a common theme within many of the articles included in this study (Carréon et al., 2005; McKenna & Millen, 2013; Naqvi et al., 2015; Posey-Maddox, 2017b; Sime & Sheridan, 2014; Warren et al., 2009). Families are especially at a disadvantage when they have a lower socioeconomic status, do not speak or understand English well, and when they do not share similar cultural backgrounds as the educators in their school (Carréon et al., 2005; Posey-Maddox, 2017b).

Some authors report that working-class families have a difficult time engaging in their children's education due to the many systemic barriers that they face (Sime & Sheridan, 2014). Programs aimed at assisting working-class families tend not to address the systemic barriers, but place more pressure on these families to engage in ways defined by the school (Sime & Sheridan, 2014). This can lead to families feeling patronized or

inferior instead of empowered (Naqvi et al., 2015; Sime & Sheridan, 2014). Explicit effort is required to address the inequities between middle class educators and low-income families by focusing on relationship building and emphasizing 'relational power' where educators and families work together instead of one having power over the other (Warren et al., 2009).

The literature also included discussion of how language is connected to power. When families have limited familiarity with English and find it difficult to express their views and opinions around their child's education, the power is unbalanced between educators and families (Carréon et al., 2005). If no interpreter is present, families may feel a lack of respect and may have to rely on their children to translate, which further impacts the power held by the family (Carréon et al., 2005).

Finally, some articles highlighted how culture can have an impact on a family's power and overall experience of engagement. Different cultures place greater emphasis on activities that may not be aligned with the school's dominant culture and may not be recognized in traditional views of engagement (Carréon et al., 2005, Posey-Maddox, 2017b; Warren et al., 2009). For example, immigrant families may pull from their life experiences and engage in specific practices to support their child's learning that may not be aligned with the school's views. Some immigrant families value strict discipline and completion of homework, whereas others may value their children maintaining respect towards teachers over other attributes, such as self-initiation or leadership (Carréon et al., 2005). As a result of this disparity, educators can delegitimize efforts to support or engage

in a child's education that are specific to a family's culture and beliefs (Posey-Maddox, 2017b; Warren et al., 2009).

Families' confidence, beliefs, and supportive life contexts

The final set of preconditions essential to the promotion of family engagement is related to the family. Does the family have confidence in their capabilities related to engaging in their child's education and learning experiences? Do they believe that it is their role to be engaged in their child's learning? Does their life context allow for them to have the time and energy to engage in ways that they want to engage? Without confidence, the belief that it is their role, and supportive life contexts, such as time and energy, the authors of the included studies indicate that family engagement is difficult to attain.

Confidence and capacity. When families have confidence that they can make an impact on their child's learning, they engage more (Baker et al., 2016); yet, many families do not feel confident in their skills and abilities. This is especially true for immigrant families who do not have familiarity with the school system (Barton et al., 2004; Carréon et al., 2005; Watt, 2016), families who do not speak English well (Carréon et al., 2005; Greenberg, 2012; Ishimaru et al., 2016; Watt, 2016), and families who had negative school experiences in their own childhood (Baker et al., 2016; Goodall & Montgomery, 2014; Greenberg, 2012; Sime & Sheridan, 2014). Challenges navigating the system, difficulties communicating with educators, and general discomfort related to educational activities put these groups at risk of feeling inferior to educators, and having low levels of confidence. For schools to ensure family engagement is possible for all families, it is

essential that there are efforts made to overcome racial, cultural, and other boundaries that lead to families' low levels of self-efficacy (Ishimaru, et al., 2016).

Beliefs. The literature indicates that families' beliefs about engagement dictate how they engage in their child's learning and education (Baker et al., 2016; Jensen & Minke, 2018; Mutch & Collins, 2012). Some families believe they are responsible for their child's education, or that they share the responsibility with their child's teachers; in contrast, others believe the responsibility lies with the school alone and, consequently, do not take active roles with respect to engagement. In addition, some families believe that they can only 'speak when spoken to' when it comes to communicating with teachers (McKenna & Millen, 2013). This belief may limit their engagement, especially if teachers do not communicate on a frequent basis. Overall, family engagement is enabled when families feel their engagement efforts are valued by educators, and are beneficial in supporting their child's learning (Mutch & Collins, 2012).

Supportive life contexts. In addition to a family's confidence in their abilities and beliefs about engagement, their specific life contexts are also important in supporting engagement with their child's learning. Many articles report that it is easier for families to engage when they have the time, energy, and resources (Baker et al., 2016; Barton et al., 2004; Carréon et al., 2005; Jensen & Minke, 2018; Mutch & Collins, 2012). For example, it is easier for families to engage when they have flexibility in the hours that they work to allow them to attend school events and engage in ways that they would like to engage, or when they have access to childcare to attend meetings at the school (Baker et al., 2016). While many authors acknowledged barriers to family engagement, such as a lack of

transportation to get to the school and inflexible work schedules, Naqvi and colleagues (2015) indicated that the issue may not be with a lack of supportive life contexts but actually in the ambiguity of the term 'engagement' itself. If engagement is defined more broadly, then there may be fewer barriers to what we consider family engagement. Therefore, it is easier for families to engage in family engagement activities that take place at the school if they have the time, energy, and resources, but perhaps families are engaging in their child's learning in other ways that should also be considered engagement.

Outcomes

Three studies linked child-related outcomes to family engagement. Outcomes reported in these studies included academic achievement (Liu & White, 2017, Jensen & Minke, 2018; Watt, 2016), high school completion rates (Liu & White, 2017, Jensen & Minke, 2018), and child social-emotional functioning (Jensen & Minke, 2018). Only one study empirically investigated the impact of family engagement on child outcomes (Liu & White, 2017). The two other articles reviewed the education literature and presented the existing evidence related to outcomes of family engagement (Jensen & Minke, 2018; Watt, 2016).

Liu and White (2017) used data from the High School Longitudinal Survey collected by the National Center for Educational Statistics to explore whether certain indicators of family engagement could predict academic success and dropout rates for youth of various racial backgrounds and immigrant generation status. In that study, family engagement was measured through survey items deemed to be reflective of parental

school involvement (i.e., attending an event at the school), parent-child communication (i.e., discussing school course work), and parental participation in extra-curricular activities with students outside of school (i.e., attending a museum together). The authors concluded that higher levels of parental engagement predicted better test scores and a decrease in school dropout rates for youth across racial and immigrant generation status backgrounds.

Jensen and Minke (2018) reviewed the literature around family engagement in secondary schools and discussed how it can influence academic achievement, high school completion rates, and youth's social and emotional functioning. They reported that greater levels of family engagement lead to higher academic achievement, increased high school completion rates, and positive social-emotional functioning outcomes. However, some of the articles they included in the review were specific to school-centric parental involvement making it difficult to discern whether these outcomes could be extrapolated to broader conceptualizations of family engagement.

Watt (2016) distinguished family engagement as home-based, and involvement as school-based. This author reviewed the family engagement literature and determined that home-based, attitudinal forms of family engagement lead to better educational outcomes when compared to school-based forms of involvement. It seems this determination was based on whether the original studies included in this review were focusing on family engagement or involvement, and whether the action took place at home or at school, but this is not made explicit. Therefore, it is difficult for the reader to know how the concept

was defined in each of the reported studies, which makes it difficult to interpret the conclusions made by the author.

Overall, the empirical evidence regarding outcomes is minimal. This may reflect the immaturity of the concept given that the definition and boundaries are still emerging, and it is difficult to test a concept that is not clearly defined. Since family engagement is a multi-faceted concept that encompasses other concepts, this makes it even more difficult to study empirically.

Discussion

Due to the scarcity of research on family engagement in SBRS, we explored the educational literature to better understand how family engagement is conceptualized in education. Our aim is to offer insight to therapists who work in the educational context. Specifically, by drawing on the main characteristics of family engagement highlighted in the education literature, we propose a broad definition that we hope will advance these efforts. Additionally, we suggest educators and SBRP consider the proposed definition and the identified preconditions when attempting to maximize family engagement in educational settings. The implications for SBRP are discussed throughout.

Adopting a broad definition of family engagement

The findings in this study demonstrate the need for a broad understanding of family engagement that allows families who engage in non-traditional ways to feel welcomed and respected in the school space. However, there is not an existing singular definition of family engagement to guide this understanding, and to challenge traditional views. In

response to this gap in the literature, we developed the following proposed definition using the main characteristics of family engagement from the included literature:

> *Family engagement is a multi-faceted 'umbrella' term used to describe families' and educators' attitudes and actions towards children's education, and the dynamic process families and educators/schools participate in to support children's learning and education across multiple environments. Family engagement is characterized by reciprocal relationships between families and educators encompassing communication, collaboration, shared power, and mutual responsibility for child outcomes. Family engagement is shaped by the individualized needs of the family, their culture, and their past experiences.*

To be consistent with indicators of concept maturity (Morse et al., 1996), our definition is meant to be broad enough to be applicable to any circumstance or context relating to how families and educators work together to support a child's learning and education.

Our proposed definition includes all attitudes and actions a family member might have towards their child's learning. School-centric activities, such as volunteering at the school, are still included in this definition but are no longer the main focus as with the term parent involvement (Barton et al., 2004; Sime & Sheridan, 2014; Warren et al., 2009; Watt, 2016). Rather, our proposed definition shifts the focus to the families' attitudes and the actions they take towards their child's learning across a variety of contexts (home, school, and community). This is an important shift because many families are not able to participate in school-centric activities secondary to their work schedules, family demands, or difficulties communicating in English (Baker et al., 2016; Carréon et al., 2005; Greenberg, 2012; McKenna & Millen, 2013). Families may not be able to attend a school trip, but they may take their child to a museum, discuss their future

aspirations, or facilitate their child's engagement in learning about their family's cultural practices (Posey-Maddox, 2017b; Watt, 2016). It is important that educators and SBRP broaden their understanding of engagement and refrain from taking a deficit-view when parents are unable to attend the school, as families are likely already engaging in ways that are meaningful and manageable for them (Carréon et al., 2005, Posey-Maddox, 2017b; Warren et al., 2009).

Although research comparing parent involvement behaviours and family engagement behaviours lacks clarity because of the ambiguity of these terms, some authors have suggested a family's engagement with a child's learning is more beneficial for academic outcomes than simply being involved with the school (Harris and Goodall, 2008; Watt, 2016). While further evidence is needed, maintaining a broad understanding of what constitutes family engagement, rather than emphasizing school-centric activities, may be more beneficial for children's educational outcomes, and is essential for promoting a more inclusive school experience for all families.

Our proposed definition highlights not just the families' actions, but the educators' actions too. Baker et al. (2016) reported that when teachers communicated with families consistently, students were more engaged academically and had fewer behavioural incidents. To support engagement, educators should explore ways to adapt their practices to be accessible for all families with whom they work by ensuring various communication methods are in place (e.g., email, notes home, class websites). Opportunities for bi-directional communication should be offered frequently, rather than limiting opportunities to parent-teacher conferences that happen infrequently throughout the year, with the

timing and duration being dictated by the school (Baker et al., 2016; Mutch & Collins, 2012; Watt, 2016). Additionally, school administrators should ensure resources are available for educators and families to connect and communicate when desired (i.e., translation services, translators) (Carréon et al., 2005).

As part of the school community, SBRP need to consider adopting a broad definition of family engagement as well. The literature on family engagement in pediatric rehabilitation indicates family engagement is co-constructed by the family and the therapist (King et al., 2020). Similarly, a study exploring family engagement in pediatric occupational therapy suggested that how the therapist reacts and responds to a family's feelings determines whether that family will be engaged or disengaged (D'Arrigo et al., 2019). However, to react and respond, the therapist needs to offer an opportunity for back-and-forth communication, which can be difficult in the school setting where face-to-face interactions are not always feasible. Providing choices to parents for methods of communicating (e.g., email, phone, or other technology) has been suggested as a reasonable option for promoting engagement in settings where 'in-therapy' communication cannot take place (D'Arrigo et al., 2019).

Overall, the focus of family engagement should be on the interactions between educators, SBRP and families, rather than the actions of families alone. SBRP and educators should consider how their actions influence family engagement, and what they could do to support the co-construction of engagement with families. Further research is required that specifically explores how SBRP can alter their actions to better facilitate family engagement with families in SBRS.

Maximizing family engagement in educational settings

Of course, our proposed definition is not directly transferable to family engagement in SBRS and will need further research with SBRS stakeholders; however, some of the major ideas within our proposed definition are supported by the existing rehabilitation literature, such as the importance of establishing trusting family-therapist relationships (D'Arrigo et al., 2019; Fingerhut et al., 2013; Kennedy et al., 2020), and the necessity for therapists to consider the individualized needs of the family to maximize family engagement (D'Arrigo et al., 2019).

Importance of trusting family-therapist relationships

As noted in our findings, the relationship families have with educators is reported to be an essential precondition to the development of family engagement. This resembles major themes in the existing rehabilitation literature. For example, D'Arrigo and colleagues (2019) reported that when the family trusted the therapist, was comfortable with the therapist, and felt understood and respected, this facilitated a good parent-therapist relationship and helped support overall engagement. Similarly, Fingerhut et al. (2013) acknowledged the importance of establishing family-therapist relationships in delivering family-centred care in SBRS. However, despite the indication that relationships with families are important, family-therapist relationships have been challenging to develop in the school setting (D'Arrigo et al., 2019; Fingerhut et al., 2013; Kennedy et al., 2020). Competing demands of therapists (e.g., lack of time, other demands of the job) and families (e.g., working during the day), lack of consistent and predictable services, lack of awareness of SBRS services, and sociodemographic factors

(e.g., cultural diversity, languages spoken) impact the ability to build relationships with families (Kennedy et al., 2020). Unfortunately, there is little evidence to guide SBRP in overcoming these barriers, and further research is required that explores both therapist and family perspectives (Kennedy et al., 2020). Overall, the literature demonstrates that the relationship educators and therapists establish with families is foundational in promoting family engagement in educational settings, but further research with all stakeholders is required to explore barriers and develop solutions that work for all.

Individualized needs of the family

As demonstrated by our findings, family engagement in education is reportedly shaped by the family's and educator's attitudes and actions, as well as the individual needs of the family, their culture, and their past experiences. Rehabilitation researchers suggest therapists' responsiveness, or their "sensitivity, flexibility and ability to adapt sessions to suit family characteristics and circumstances" (p.4), is a major contributing factor to family engagement in pediatric occupational therapy (D'Arrigo et al., 2019). Therefore, the therapist's ability to be responsive to the family's attitudes, actions, beliefs, needs, and individual circumstances is essential. Families need to feel understood, respected, and supported by the therapist to maximize engagement (D'Arrigo et al., 2019).

In particular, it is important to discuss the provision of culturally sensitive care to meet the needs of diverse client populations. Providing culturally sensitive care refers to therapists' awareness of the influence of culture on families' style of communication, beliefs about health, and attitudes towards healthcare (Donate-Bartfield & Lausten, 2002).

In education, a similar concept, culturally responsive teaching, focuses on attending to the unique cultural qualities of students and their families (Abacioglu, Volman, & Fischer, 2020). Therapists and educators need to be able to support families with diverse backgrounds around navigating the education and healthcare systems, being a part of the team supporting the child, and making informed decisions around their child's education and overall development. These actions may help to facilitate strong educator, therapist, and family relationships by supporting three of the preconditions to family engagement: increased trust, improved communication, and shared power. However, both educators (Abacioglu et al., 2020), and therapists (Lindsay, King, Klassen, Esses, & Stachel, 2012) require further training to provide culturally sensitive and responsive services to families from diverse backgrounds.

Limitations

This study has some limitations. Due to the ambiguity between parent involvement and family engagement, parent involvement was not included as a search term; however, this may mean that some studies concerning family engagement were overlooked. Additionally, the included articles were limited to those written in English and pertaining to kindergarten to grade 12 education only. Including articles written in other languages or in early educational settings may have provided greater clarity of the concept.

Conclusion

In this study, we offered a broad conceptualization of family engagement, and an evaluation of the maturity of this concept for educators and therapists working in SBRS.

Although further research is certainly required to further delineate this concept from bordering concepts, the definition presented in this study is an appropriate next step in concept development. Educators can consider how applying a broader definition of family engagement may facilitate trusting relationships, and shared power with families. They may also wish to consider actions they can take to better meet the individualized needs of the families in their class. Ensuring that bi-directional communication with families is welcomed and accessible is a good starting point.

Until further qualitative research is completed exploring family engagement more purposefully in SBRS, therapists working in educational settings can use the findings in this study to consider the many preconditions that support family engagement in educational settings, and actions that could be taken to meet the individual needs of each unique family.

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Table 1. Concept evaluation indicators of concept maturity

Evaluation Component	Component Meaning (Morse et al., 1996)	Indicators of Maturity (Morse et al., 1996)
Definition	The concept is labelled and has a meaningful definition.	A concept that is mature is clearly defined in the literature. The definitions are consistent and cohesive by all researchers exploring the topic.
Characteristics	The distinguishing characteristics or defining features of a concept.	A concept that is mature has defining characteristics that are clearly described in the literature. The characteristics should be broad enough that they can be true in any context, and unique enough to define the conceptual boundaries.
Boundaries	The boundaries of a concept outline what a concept is, and what it is not.	A concept that is mature has clearly delineated boundaries that outline the distinguishing features that make it unique.
Preconditions	The preconditions are the conditions in place for the concept to occur.	A concept that is mature has identified preconditions that must be present for the concept to develop, or the perceived behaviour to occur.
Outcomes	The outcomes are the results or implications of the utilization of the concept.	A concept that is mature will have similar outcomes that are a result of the concept in all instances.

Table 2. Concepts and related search terms

Concept 1	**Concept 2**
Parent/Family Engagement	School/education
Keywords: "parent* engagement" "famil* engagement" "parent* partner*" Subject Headings: Parent school relationship	Keywords: school* education* "K-12" "K-8" academic* "student success"

Table 3. Included article descriptions, and definitions of family engagement

Reference	Article Type	Study Purpose	Definition/description or conceptualization of engagement
Baker et al. (2017)	Qualitative empirical study	Reframe notions of parent involvement (being present in the school building) to parent engagement (viewing multiple constructions of how parents are involved).	"Intentional efforts by the school to recognize and respond to parents' voices and to help school staff to better understand how to address barriers that parents have identified"(p.163). "Collaboration built on multiple constructions of how parents are involved"(p.164).
Barr & Saltmarsh (2014)	Qualitative empirical study	Explore Australian parents' views about their experiences with parent engagement.	"Parent engagement as an umbrella term to encompass a broad range of activities" (p.492). Specific forms include engagement at home, in classrooms and playgrounds, or in decision making roles as parent representative bodies or participation in advocacy groups. Engagement is a signifier of a range of orientations, attitudes and activities through which parental interest and engagement with their children's education may be expressed.
Barton et al. (2004)	Theoretical paper	Present a new data-driven framework for understanding parental engagement in urban elementary schools, the Ecologies of Parental Engagement (EPE) framework.	Parent engagement is "a dynamic, interactive process in which parents draw on multiple experiences and resources to define their interactions with schools and among school actors" (p. 3).
Carreón, Drake & Barton (2004)	Qualitative empirical study	Provide an understanding of immigrant parents' engagement in urban schooling through use of the Ecologies of Parent Engagement framework.	Engagement includes the specific things parents do, but also "includes parents' orientations to the world, and how those orientations frame the things they do" (p.469)

Goodall & Montgomery (2014)	Theoretical paper	Present a model for the progression from parental involvement with schools to parental engagement with children's learning.	Engagement encompasses "more than just activity - there is some feeling of ownership of that activity" (p. 400). Parental engagement is "parents' engagement in their children's lives to influence the children's overall actions" (p.402).
Greenberg (2012)	Qualitative empirical study	Understand the educational engagement practices and beliefs among urban immigrant Latino families.	Parental engagement is defined as "a parent's "presence" in their children's schooling, regardless of where the engagement takes place" (p.233)
Ishimaru et al. (2016)	Qualitative empirical study	Explore cultural brokering practices in three parent and community engagement initiatives.	"Family engagement expands on traditional parent involvement approaches by recognizing broader notions of family as well as a broader set of behaviors related to student learning and development both in and out of schools" (p.853). There is an emphasis on relationships over activities, and families as leaders and change agents.
Jensen & Minke (2018)	Literature review	Review the existing literature on the parent engagement process at the secondary level and its effects on academic and social/emotional outcomes for students.	"Parent engagement is a complex, multifaceted construct that encompasses the ways in which parents support their child's education at home and at school" (p. 167-168).
Liu & White (2017)	Quantitative empirical study	Understand the links between race/ethnicity/generational status and educational performance, as well as, the distinct and mediating effect of parental engagement on educational outcomes.	"Parental engagement, which can be seen as a form of or linked to family social capital, is measured here through parental school involvement, parent-child communication, and parental participation in activities with students" (p.30).

McKenna & Millen (2013)	Qualitative empirical study	Present models of parent voice, parent presence, and engagement, and clarify the meanings and expectations that accompany much of the writing and thinking on parent engagement.	"Parent voice and parent presence, together, form parent engagement. To clarify further, parent presence does not simply reference involvement or overt participation in schools, but also includes a broad variety of subtle ways in which parents are active in a child's life, which are more difficult to quantify and measure. Likewise, parent voice does not reference inert or heretofore unheard ideas, but encompasses an authentic, two-way communicative process between educators and family members" (p.36-37).
Mutch & Collins (2012)	Executive summary	Determine to what extent school practices contribute to meaningful, respectful partnerships (defined as 'engagement') with parents, whānau, and the wider school community.	Engagement is "defined as meaningful, respectful partnerships between families and schools that focuses on improving the educational experiences and successes for the child" (p.176).
Naqvi, Carey. Cummins & Alitdor-Brooks (2015)	Qualitative empirical study	Explore the conditions under which educator-parent interaction could become identity-affirming for parents, thereby reinforcing and sustaining further engagement with the school and their children's education.	"Engagement means an emotional involvement or commitment and it is argued that participation and involvement, while important, merely set the stage for effective engagement" (p.17). Parental engagement includes learning at home, school-home and home-school communication, in-school activities, decision-making and collaborating with the community.

Posey-Maddox (2017)	Qualitative empirical study	Explore the engagement of black fathers in their children's education and the intersections of race, class, gender, and place in their experiences with a predominantly white suburban school district.	"Parent engagement as a dynamic and interactive process that is best understood through an examination of how parental beliefs, actions, and circumstances are shaped by broader social systems" (p.579).
Posey-Maddox (2017)	Qualitative empirical study	Explore Black mothers' and fathers' engagement and experiences with their children's schools and in the broader community.	"Parent engagement as a dynamic and interactive process that is best understood by examining how broader contexts (e.g. community, family, and schooling) shape parental beliefs, actions, and circumstances" (p.6).
Sime & Sheridan (2014)	Qualitative empirical study	Explore forms of capital that parents, in one disadvantaged area in Scotland, drew upon in order to negotiate their engagement with their children's education.	Parent engagement is "a multi-faceted construct including taking part in activities, and having a sense of commitment and ownership" (p. 328).
Warren, Hong, Leung Rubin & Sychitkokhong Uy (2009)	Qualitative empirical study	Present a community-based relational approach to fostering parent engagement in schools, and investigate the efforts of community based organizations to engage parents in schools in low-income urban communities.	Engagement is described as "a more active and powerful role for parents in schools" (p.2211) when compared to involvement.

Watt (2016)	Literature review	Explore the forms parent engagement can take, the impact it might have upon pupils' attainment, and the challenges that schools might face in engaging parents, particularly from lower socio-economic status groups.	Parental engagement means "any activity through which a parent (or other family member) is engaged directly in the learning of his or her child. It can incorporate a variety of activities including helping a child with homework, talking to them about their educational aspirations, reading with them and taking them on cultural excursions" (p. 32).

Legend. Theoretical paper is a paper that reviews literature or previous work but also creates a theory, framework or model. Literature review is a paper that reviews and summarizes literature, and may report thematic findings. Qualitative empirical study employs qualitative methods in the collection and analysis of data. Quantitative empirical study employs quantitative methods in the collection and analysis of data. Executive summary is a paper that summarizes a longer report or group of reports for dissemination purposes.

Figure 1. Screening Process Flow Diagram

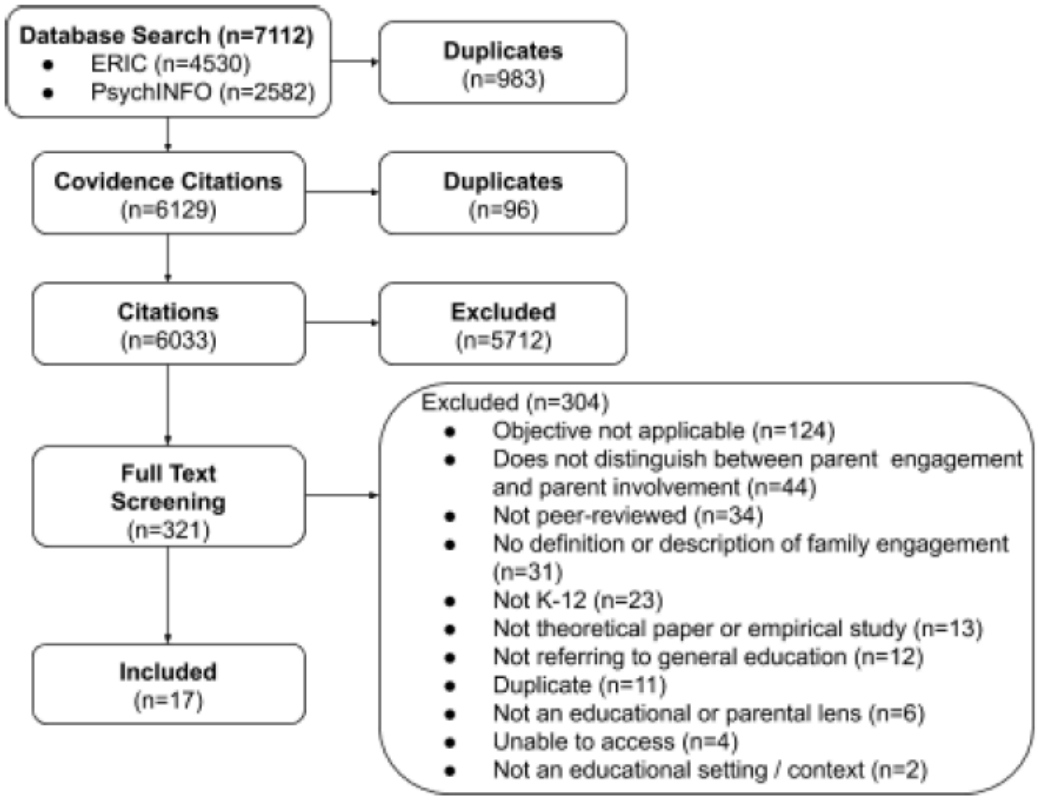
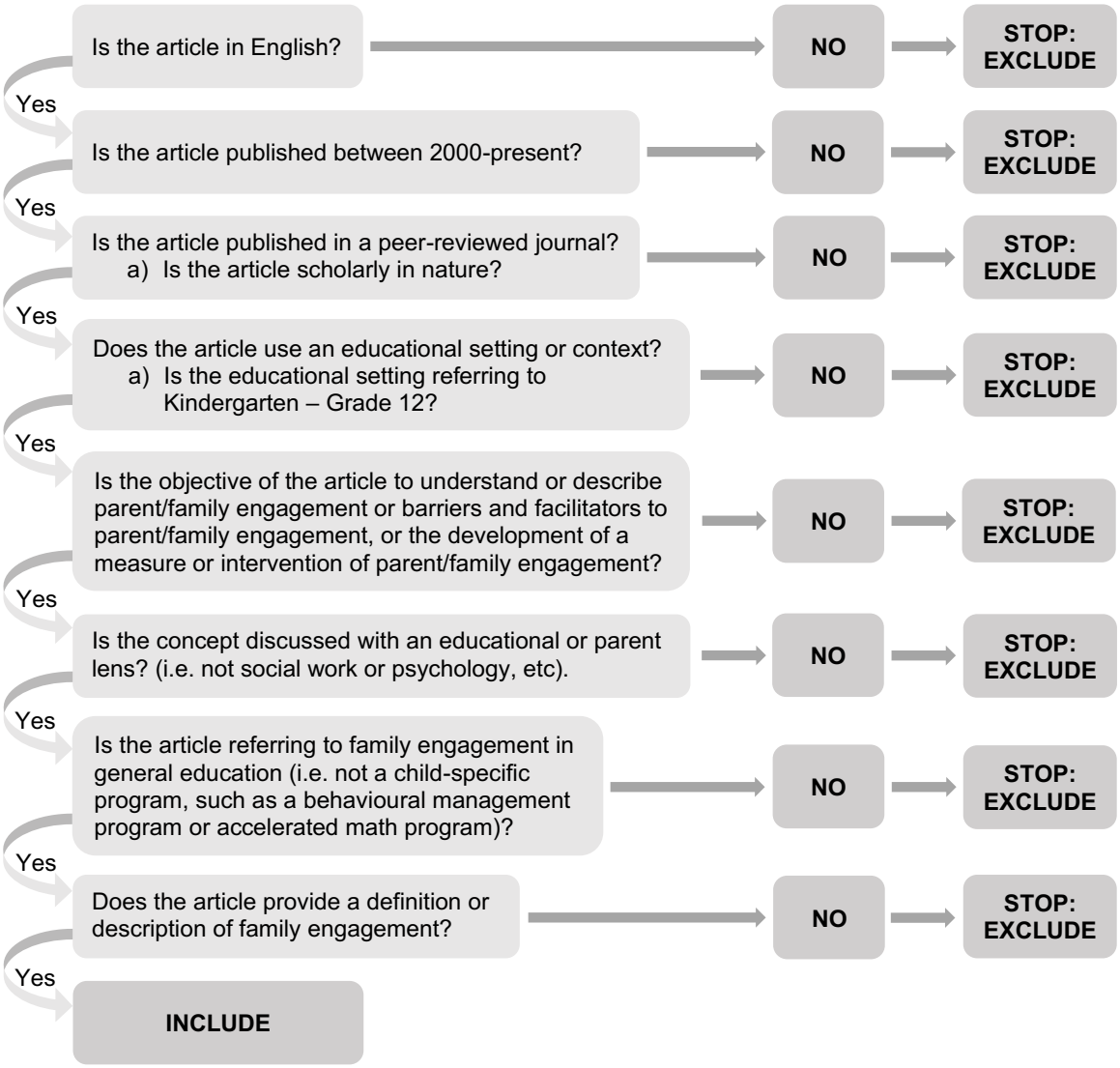


Figure 2. Inclusion Decision Tree



Chapter 3. Making Connections between School and Home: Exploring Therapists' Perceptions of their Relationships with Families in Partnering for Change

This chapter presents a qualitative description study exploring occupational therapists' perspectives of the factors that influence family-therapist relationships in the Partnering for Change service delivery model.

Published in: British Journal of Occupational Therapy

Kennedy, J. N., Missiuna, C. A., Pollock, N. A., Sahagian Whalen, S., Dix, L., & Campbell, W. N. (2020). Making connections between school and home: Exploring therapists' perceptions of their relationships with families in partnering for change. *British Journal of Occupational Therapy*, *83*(2), 98–106.

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Making Connections between School and Home: Exploring Therapists' Perceptions of their Relationships with Families in Partnering for Change

Short title: Making Connections between School and Home in Partnering for Change

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Abstract

Introduction: A recently developed service delivery model, called Partnering for Change, encourages collaboration between occupational therapists, educators, and families and aims to improve children's participation across school, home and community settings. Partnering for Change has been successful in facilitating equitable access to services and eliminating wait lists; however, it could have a more significant impact through improved capacity building with families. The purpose of this study is to describe the factors that therapists view as influencing the development of family-therapist relationships in Partnering for Change, and to explore their ideas to improve relationship-building.

Methods: Focus groups were completed with fifteen occupational therapists who provided Partnering for Change school-based services. Qualitative description methodology and directed content analysis were utilized.

Results: Several factors were identified that influenced the development of family-therapist relationships including competing demands; consistency and availability; awareness, readiness and commitment; relationship with schools and educators; and sociodemographic characteristics. Increasing in-person interactions and awareness of occupational therapy services were suggested to improve relationship-building.

Conclusions: Therapists should consider innovative ways of overcoming competing demands, utilizing relationships with schools and educators, and participating in mentorship and communities of practice to address current barriers of family-therapist relationships, and create better opportunities for collaboration.

Keywords

occupational therapy; family engagement; family-therapist relationships; collaboration; service delivery models; participation.

Introduction

Over the past decade, researchers at McMaster University in Ontario, Canada have developed, implemented and evaluated a school-based occupational therapy service delivery model called Partnering for Change (P4C) that aims to improve children's general participation at school, home and in the community. P4C is a tiered service delivery model that emphasizes relationship building and knowledge translation as pillars for building the capacity of the individuals who interact with children every day (Missiuna et al., 2012). Rather than removing children from the classroom to provide 'therapy,' occupational therapists (OTs) collaborate with educators to support children who are experiencing difficulties participating at school. The principles of this service delivery model are to "Build **C**apacity through **C**ollaboration and **C**oaching in **C**ontext" (P**4C**: Missiuna et al., 2012). In contrast to more 'traditional' referral-based models of service delivery, OTs in this model are present in the school for one full day each week, and provide classroom-wide, and more targeted or individualized services for the entire school year using a tiered, needs-based approach. Ideally, when appropriate, OTs also translate knowledge to families to improve the child's participation in home and community settings.

The success of this model depends on collaboration between OTs, educators and families across three tiers of service. In the first tier, therapists collaborate with educators to establish classroom needs and develop universal strategies that promote the growth, development and participation of all children. Although OTs might provide general education to families at this tier (e.g., child development, or self-regulation), individual

families become involved only when the therapist has determined with the educator that more targeted or individualized approaches are required for specific children. At this point consent is obtained for services, which is the beginning of the family engagement process.

Family engagement is essential when working with children on an individualized basis. Not only are families the experts on their children, they also are the bridge between home and school. Families contribute insight and expertise about their child's strengths and challenges. P4C depicts families as equal partners in this model and, in an ideal scenario, OTs implementing P4C build trusting and collaborative relationships with families to ensure children receive the support they require across home and school environments; however, therapists have previously noted that this is challenging (Missiuna et al., 2015). This study explored OTs' perspectives on the factors that influence family-therapist relationship-building in P4C.

Literature review

In pediatric rehabilitation, family engagement is considered essential to the child generalizing learned skills to other contexts and maximally participating in daily life (King, Williams & Goldberg, 2017). Since the 1990s, family-centred services, family engagement and family-provider relationships have been discussed as foundational components of health service delivery (Kalmanson & Seligman, 1992; Rosenbaum et al., 1998; Bamm & Rosenbaum, 2008). There are many frameworks and definitions of family-centred service; *CanChild*, Centre for Childhood Disability Research, at

McMaster University describes family-centred service as a philosophy and method of service delivery that recognizes families as the experts on their child's needs, and promotes partnerships between families and clinicians (Bamm & Rosenbaum, 2008). Although most literature on family-centred service is not specific to the school setting, P4C highlights the importance of involving families to help translate knowledge across contexts and includes families as equal partners in the model (Missiuna et al., 2012). Despite this aim, OTs who have delivered P4C in schools have not felt they have been able to build relationships with families the way they have with educators, limiting their ability to be truly family-centred (Missiuna et al., 2015).

This study is one component of a two-year implementation and evaluation study of P4C (Missiuna et al., 2015). After the first year of the study, OTs reported experiencing challenges building relationships with families, which resulted in knowledge translation being focused mainly on educators and reduced capacity building with families (Missiuna et al., 2015). Additionally, some families receiving the P4C service reported that, although the services were helpful, they wanted to be more involved (Missiuna et al., 2015). It became apparent that OTs might have to work differently to reach families more effectively and to increase the benefits of these services. Thus, in year two of the implementation and evaluation study, the OTs were asked to engage in focus groups to explore these difficulties in further depth, and discuss what might improve the connection and relationship with families. Therefore, the present study explored the factors that OTs believed influenced their ability to build relationships with families when delivering P4C by asking:

1. What do OTs delivering the P4C model perceive influences their ability to develop relationships and collaborate with families?
2. What suggestions do OTs have for improving relationships with families in the P4C model of service delivery?

Method

Study design

This study used qualitative description methodology which allows for a comprehensive summary of the phenomenon under study from the perspectives of the participants (Sandelowski, 2000). This method suggests presenting the findings in language that is closely linked to the language used by the participants, discouraging high levels of inference and interpretation (Sandelowski, 2000). As such, the findings yield a rich description of the OTs' perspectives of challenges and successes when building relationships with families. Ethics approval for this study was received from the McMaster University Hamilton Integrated Research Ethics Board. Only data collected in the second year of the study was used for this inquiry because the questions specficially pertained to building relationships with families.

Participants

All participants in this study were registered OTs trained to deliver P4C as part of the two-year implementation and evaluation study (Missiuna et al., 2015). Sampling was purposeful as all of the participants who participated in year two of the implementation and evaluation study were asked to participate in the year two focus groups. All OTs

engaged in the second year of the study chose to participate; however, one therapist became ill and was unable to participate in the focus group, resulting in fifteen total participants.

The participants were trained in the P4C service delivery model and received ongoing mentoring and support throughout the two-year project (Pollock et al., 2017). Each OT provided P4C services one day per week in 2 to 4 schools, resulting in 40 schools receiving P4C in two health care regions in Ontario, Canada. The participants had practiced occupational therapy from between 1 and 41 years (median = 9 years) and had delivered school-based services from between 1 and 30 years (median = 7 years). Written informed consent was obtained by all participants.

Data collection

Focus groups were completed with OTs who took part in the two-year P4C study towards the end of each school year. Therapists were grouped into each focus group based on the geographical region they delivered services. Two focus groups were completed, one with seven participants, and another with eight participants. The focus groups were conducted by an individual who was not part of the research team at the time of data collection in an attempt to reduce social desirability bias. The focus groups were completed with a semi-structured interview guide, using open-ended questions such as: *What has your experience been in terms of reaching parents and helping to build their capacity?* and *What might you suggest would make the connection with families easier?* Focus groups were audio recorded and transcribed verbatim.

Data analysis

Data analysis was completed using directed content analysis (Hsieh & Shannon, 2005) and a template analysis style (Miller & Crabtree, 1992). This type of analysis combines use of a pre-existing coding system with inductive modifications to the system throughout the analysis process (Miller & Crabtree, 1992; Sandelowski, 2000). Content analysis using a directed approach is more structured than a conventional content analysis approach, however, its key tenets remain in the naturalistic paradigm (Hsieh & Shannon, 2005).

As an initial step, the first author read the focus group transcripts multiple times to become familiar with the nature of the data. The first author wrote memos in the margins of the transcripts to highlight important points and initial thoughts. The transcripts were then analyzed using pre-existing codes aimed at answering the research questions, such as, *barriers to family-therapist relationships*. The pre-existing coding system aimed at discerning factors that influenced the family-therapist relationship, and what could be done in the future to strengthen these relationships in the P4C service delivery model. Additional data-derived codes were developed through immersion in the data and were more inductive in nature. This approach to analysis is reflective of 'template analysis style' (Miller and Crabtree, 1992) and aligns with qualitative description methodology (Sandelowski, 2000). The pre-existing coding scheme and additional data-derived codes were applied to the focus group data by the primary author using QSR International's NVivo 11 (2015) software. Preliminary findings were discussed with the research team through a peer review process, which resulted in some coding categories being combined

and codes redefined. The transcripts were then re-coded based on the second coding scheme.

Findings were once again presented to the research team consisting of expert colleagues who designed the P4C model and colleagues who served as mentors to the OTs throughout the two-year implementation and evaluation study to ensure congruency and transparency, and to enhance overall credibility. Using a research team rather than an individual researcher also strengthened the dependability and confirmability of the findings (Letts et al., 2007). Additionally, the first author engaged in reflexivity through use of reflexive journaling in an effort to enhance credibility and trustworthiness.

Findings

Analysis of the focus group data revealed several insights into the factors that influenced family-therapist relationships. These insights were organized into two descriptive categories: factors that influence the development of family-therapist relationships, and suggestions for improving these relationships.

<insert Table 1 about here>

Factors that influence the development of family-therapist relationships

Within this broader category, therapists discussed five main factors that influenced the development of family-therapist relationships in the P4C model: competing demands; consistency and availability; awareness, readiness and commitment; relationship with schools and educators; and sociodemographic factors.

Competing demands. The OTs discussed many competing demands that influenced their ability to build relationships with the families of the children they were servicing. Some therapists found that they were more focused on building partnerships with schools and educators, instead of parents. 'I … needed to be a bit more creative as to how to incorporate the parents because I think… they are a valuable piece of all of this (OT10).'

Others described lacking time to build relationships due to the many other demands of the job, which is further complicated by the time constraints that families face. 'I find a lot around time is an issue, time on our part because we have so many kids to see but also time on [families'] part… (OT2).' In particular, the OTs acknowledged it is especially difficult to connect with families who work in the daytime. One participant stated, 'There are also a lot of issues with them being at work while we are in the school so we don't have that ability to actually connect with them like on the phone all the time (OT4).' Prioritizing relationships with educators, lack of time, and parents' competing demands all influenced the OTs' efforts to connect with families and build relationships.

Consistency and availability. The OTs reported they felt it was easier to connect and collaborate with families when services were provided consistently and predictably. Having a consistent day of the week that families could expect them to be at the school allowed therapists to build relationships more easily. One OT stated, 'Being … there every Wednesday …then families know … you can call me at 8 o'clock in the morning I'll be at the school, so the consistency is very helpful for connecting and collaborating with families (OT1).'

The OTs also spoke about the benefit of being available to families throughout the school year compared to other models of service in which the therapist is only available for the timeframe that the child is receiving services. The OTs indicated that the P4C model allowed for increased availability, which led to ongoing and increased communication with families.

> In the old model you only have how many visits and we only …meet with the parents once and I don't think that the communication is that open in the old model cause you are there for such a short time. So with this model… it's kind of nice cause you are there with open communication for the year (OT7).

However, the OTs indicated that the broad focus of the P4C service (the whole school, compared to individually referred children) may have contributed to a lack of consistent presence, and a lack of availability, making it challenging to connect with families:

> Again I don't know why I feel so strongly about this but I do feel if it had been kind of a narrower focus we would have been more visible…[be]cause week to week you'd be floating from one class to the next and to try to cover all your bases and see everybody and had it been a narrower population maybe that we were seeing I think we would have been a little bit more visible (OT15).

Additionally, therapists indicated that the size of the school influenced the accessibility of families to therapists.

> I will say that at a smaller school where I felt the parents were more accessible in terms of drop off or pick up I did have a few more relationships with parents. At my larger school almost none other than the odd phone call I would have made with, you know, respect to something we were working on or the contact I made with all the parents in the beginning of the year as the new OT in that school, but

even with that, many parents didn't call me back (OT9).

Overall, factors that contributed to better opportunities to connect with families were the OTs' consistent weekly presence in the school and year-round service. However, the broad focus of the service and large school sizes negatively influenced opportunities for relationship-building.

Awareness, readiness and commitment. To build relationships, OTs suggested families needed to be aware of the occupational therapy services that are offered, feel a sense of readiness to engage with these services, and be committed to working collaboratively with the therapist. Additionally, OTs indicated that they themselves needed to be committed to working with families, and believe that their efforts were worth the time required to engage with families.

Regarding awareness, one OT stated, 'I don't think that parents have been as involved as they possibly could have been and I don't know if that's because they just didn't know (OT11).' In addition to awareness, families also need to have a certain level of readiness to engage in occupational therapy services. Many of the OTs discussed how the change in the service delivery model led to earlier identification, which influenced the dynamic between therapists and families. Families were no longer put on wait lists for services and this may have had an influence on their readiness for services.

> I think that part of that is related to the fact that we are doing things a lot earlier now so the kids that go on a waitlist for two years, [the families] have had two years to process that this student is having difficulties … whereas now we are … sometimes the first point of contact so the parents haven't either processed it or they haven't had time to accept it because a lot of the times [the students] are in

> kindergarten or … the issues are starting to kind of come into play and the parents aren't either…ready to accept it or they haven't really seen it or had an opportunity to understand that piece of it (OT2).

Families are not used to having OTs providing service for all children in a school and may feel uneasy about this: '…because we haven't had OTs in the school working with kids who don't have special needs, the idea of your child seeing an OT was a bit standoffish for a lot of parents (OT14).'

Not only do families need to have a certain level of readiness, but OTs do as well. In P4C therapists now have the responsibility of identifying children who are experiencing challenges in school, and delivering this message to the family. This is a major role shift because previously other individuals, such as a teacher, first noted the child's difficulties and then referred the child to occupational therapy. Even though parents are informed at the beginning of the school year that an OT will be present in their child's classroom, and might notify parents if there are additional concerns based on their observations, families are sometimes still unprepared to process this information.

> …with the old model the parents are already very much aware that their child is on the waitlist and they are very anxious for their child to receive service. I find I'm having to do a sales pitch more with children that I am identifying and that tends to require more of the art of communication and the art of diplomacy and how you are communicating your observations and the school to be on board with . . . it certainly did add an element of stress to the position (OT5).

Finally, the OTs reported that families require a certain level of commitment to facilitate a successful relationship between the therapist and family.

> … either they want to connect with you or…they don't. I find there's not really a middle ground . . . And the parents who do want to connect with you the knowledge translation is wonderful . . . most of the time [parents] aren't making contact even if we try to call them and leave a voicemail, but it's nice to focus on the parents who do . . . [be]cause you know you have more of a lasting impact on the client (OT7).

Factors that influence relationship-building between OTs and families include family awareness of services, family and therapist readiness, and overall family commitment to the service. Having awareness, readiness and commitment might lead to increased communication and enhanced connections between therapists and families.

Relationship with schools and educators. Therapists reported that their relationships with the schools they work in and the educators they work with helped to facilitate connections with families. Specifically, when there was a team approach to connecting with parents, the outcome was positive.

> I felt that my most effective way of connecting with families was through staff. That was always my best way of connecting because they had already discussed things or they went back to parents. It always seemed to work best when it was part of a team effort versus my trying to call people (OT15).

However, the OTs also indicated that sometimes the schools were not supportive of their ideas, which limited their ability to be creative and offer services that may have improved parents' awareness; this, in turn, constrained their opportunities to make connections. 'I have tried [to offer a parent night] in the past but unfortunately … the schools were not so keen … cause they've already got so many other things going on… (OT4).'

Despite instances where the school could have done more to support their efforts, most OTs indicated that, when relationships with families were successful, educators played a major part facilitating the connections and ensuring collaboration.

Sociodemographic factors. Family and school specific sociodemographic factors reportedly had an influence on OTs' ability to connect and build relationships with parents. For example, when therapists do not speak the same first language as parents, it can be difficult to translate knowledge in ways that are useful for families: '…a lot of times we actually have a language barrier that… creates a bit of an issue obviously for them understanding what we are actually doing with their child (OT4).'

Therapists indicated that the sociodemographic identity of the school has a significant influence on how the information is received and prioritized by families.

> At one of my schools, the families are quite transient and again I think the school has issues with communications with parents so I see that being reflected in how I am portraying or trying to implement P4C. And as well, I have another school that culturally things are very, very different so again the concerns of some of the students, the motor piece of it might not necessarily be the biggest issue. So not that the school or the families aren't welcoming but it changes the level of understanding and it changes I guess the priority… there is definitely very, very different cultures economically, socially… culturally with the different schools that I'm working in (OT8).

Each school and neighbourhood has a different sociodemographic make-up that can influence the way information is received or understood by parents, which ultimately influences how OTs can build relationships with families.

Suggestions for improving family-therapist relationships

Therapists providing P4C services had many suggestions for improving relationships with families. Therapists spoke about organizing summer camps or groups specific to children with certain types of challenges, and hosting events when families were already coming to the school, such as during parent-interview nights. They indicated that these activities would allow for greater face-to-face interactions with families, which may lead to increased opportunities for family engagement. For example, one OT suggested a way to build connections with families prior to students starting their first year of school:

> One of my schools has … an early years' programme. It's a culturally diverse area so moms or parents of pre-schoolers … have a room in the school so they get introduced to English and different fine motor activities, scissors, arts and crafts. So one of the teachers suggested that I touch base with the lady that runs the programme and start to build a relationship there … they thought that that would be a really great opportunity to sort of bridge that early intervention piece (OT8).

These strategies provide ways to connect with families in person and promote opportunities to demonstrate the importance of occupational therapy.

Additionally, the OTs discussed ways to increase families' awareness of their services, through newsletters or attendance at information nights.

> …at the start of the school year I made sure I had something in the newsletter, please contact me if you have questions and I had a couple of parents who did call and because it was parent initiated I have been able to have a bit more communication back and forth (OT13).

Increasing awareness and creating more opportunities to connect with families face-to-face were the main suggestions provided by the therapists.

Discussion and implications

This study described what OTs delivering the P4C model perceived to influence collaboration and relationship-building with families. Participants discussed five main factors: competing demands; consistency and availability; awareness, readiness and commitment; relationship with schools and educators; and sociodemographic factors. Additionally, the participants had suggestions for improving these relationships; specifically, increasing parents' awareness of their presence in the school, and building on existing school events to meet with families in-person. This discussion explores some of the factors noted to influence family-therapist relationships, builds on the suggestions made by the therapists in this study, and provides considerations for OTs implementing P4C or similar models of service delivery.

Overcoming therapist and family demands

Many OTs highlighted competing demands, their own, or families', as being a major barrier to connecting and collaborating with families. Therapists practicing in this model perceived other priorities or areas of focus, such as connecting with teachers, limited the time available to connect with parents. They also acknowledged the demands of working families and the impact on parents' ability to be present in the school environment. However, when asked what could be done to improve relationship building, no suggestions were offered to manage these competing demands. Instead, therapists

expressed that they valued face-to-face interactions with families and suggested ways to increase opportunities to connect in-person. It should be noted though that increasing expectations for in-person interactions might actually increase the demands placed on families.

A grounded theory study exploring parents' attendance, participation and engagement in services delivered at a children's treatment centre found that families face many competing demands that influence their ability to attend and participate in services (Phoenix et al., 2019a, 2019b). The Phoenix Theory of Attendance, Participation, and Engagement (Phoenix et al., 2019a, 2019b) demonstrates how factors such as the number of adults contributing to the child's therapy, the number of children living in the home, access to transportation, full-time work, and challenges finding child care for other children, lead to difficulties attending and participating in therapy services. Although not directly generalizable to the school environment, it is plausible that similar demands also would apply to families who are asked to attend meetings with school-based therapists.

There may be other ways to connect with families. Educators have suggested strategies for improving parent involvement in general education that may be relevant to school-based occupational therapy services. For example, educators are using technology to improve communication and connection with families (Blau & Hameiri, 2012; Muir, 2012; Olmstead, 2013; Ozcinar & Ekizoglu, 2013; Snell et al., 2018; Tobolka, 2006). These types of interventions allow families to communicate with teachers and learn about their children's school progress remotely (Tobolka, 2006), and are considered especially useful for families who find it difficult to connect with teachers during typical working

hours (Snell et al., 2018). Currently, there is no evidence available to determine whether technology-based communication strategies would be effective at enhancing collaboration between OTs and parents in the school setting; however, it is an idea worthy of exploration.

Utilizing relationships with schools and educators

Relationship-building with educators has been established as an essential ingredient of the P4C model (Missiuna et al., 2012). According to school-based occupational therapy literature, it is critical for therapists to spend time developing strong relationships with educators and to become a part of the school community to establish trust and clarify expectations (Case-Smith & Holland, 2009; Hasselbusch & Penman, 2008; Rens & Joosten, 2014; Swinth, Spencer, & Jackson, 2007; Villeneuve, 2009). Therapists in this study acknowledged the importance of establishing relationships with the school and educators and spoke about how influential these relationships can be when working with families. Despite this, when asked how they might improve connections with families, therapists did not discuss utilizing these relationships to build trust with families.

The revised Theoretical Model of Parental Involvement outlines what influences parents' decisions to become involved in their children's education, and the types of parental involvement (Walker et al., 2005). Although this model is specific to parents' involvement in general education, it may be relevant to consider for occupational therapy services that occur in the school setting. One component of this model that seems

particularly relevant is *parents' perceptions of invitations for involvement from others*. This factor refers to parents' views regarding how the school, teacher and child feel about involving them in the education process. The model suggests that families who feel welcomed by the school, teacher, and their child are more likely to become involved than families who do not feel welcomed (Walker et al., 2005). OTs should focus on ensuring that the invitation to be involved in general education is extended to involvement in occupational therapy services. This begins with ensuring a trusting relationship with the educators and becoming a part of the school community (Campbell et al., 2012).

Utilizing relationships with schools and educators may also serve well in circumstances where therapists' consistency and availability is not sufficient for building relationships with families. Therapists in this study noted that their consistent weekly presence in the school allowed for greater availability and more opportunities to connect with families most of the time; however, there were certain circumstances where consistency and availability were ineffective at providing opportunities to connect with families, such as when the school was large and had a high volume of students. In these large schools, the therapist's availability is thinly spread, making them less consistently available. In these circumstances, it is even more important to utilize relationships with schools and educators to discuss appropriate plans of action for service delivery that best meet the needs of individual schools. By developing a more individualized action plan, the therapists could also begin to better understand the school's sociodemographic culture, and overall needs.

Training and mentorship to support the shift in OTs' role

P4C involves a new role where therapists are typically the first to inform families about challenges a child may be experiencing. The OTs in this study indicated that this is a change for both therapists and families. In more traditional models, the teacher typically refers children for occupational therapy services and families have time to process information about their child while waiting for services to begin. In the P4C model, therapists require a novel set of skills to initiate these difficult conversations with families, which reportedly induces feelings of stress for therapists.

The OTs in this study historically worked in traditional models of school-based services (providing one-to-one support to children). As such, the research team developed a comprehensive, multifaceted training program (Pollock et al., 2017) to ensure therapists felt comfortable implementing P4C; however, the OTs still reported stress with this shift in service delivery. Stress related to self-efficacy can be a barrier for practitioners who are experiencing changes in practice (Straus, Tetroe, & Graham, 2009). Despite the multifaceted training program, therapists continued to require time to practice these skills and adapt to new roles. Ongoing mentorship, and an established community of practice were vital for therapists to manage the significant changes in practice that occurred in this study (Pollock et al., 2017) and are recommended for clinicians adopting the P4C model of practice.

Not only is this model a shift for OTs, but for families as well; which might be why therapists in this study spoke to a lack of family readiness and commitment related to

these services. It is likely that families are also still learning and adapting to this new model of service delivery and perhaps needed more time to feel open and comfortable with the substantial changes.

Future directions

Professional and societal demands on therapists and families are increasing (Luxton, 2011). Although face-to-face communication is still highly valued by therapists, unique ways are needed for therapists and families to connect. Qualitative research with therapists and families is required to explore ways these stakeholders can connect and collaborate despite competing demands. Additionally, future research might explore how OTs can capitalize on their relationships with educators to create a system that is more inviting for families. Therapists and educators should be included as participants in these studies. It also is recommended that future studies involve interviews with families to discuss how readiness for service provision differs in a model where the OT is the first to identify when a child is experiencing challenges in development or participation in school.

Limitations

Focus groups do not always allow for all participants to have an active voice. Although the interviewer attempted to ensure all therapists participated, some did not contribute to the discussion and their voices may not be represented in the findings. The descriptive nature of this study provided important preliminary information; however, other methods such as individual interviews could provide a more nuanced and richer

understanding. Member checking was not completed with participants to verify the data. Instead, the first author debriefed with expert colleagues who designed the P4C model and served as mentors throughout the two-year study. Finally, this study would have benefitted from families' perspectives. The family voice would have provided a richer understanding of the factors that influence the family-therapist relationship.

Conclusion

This study aimed to understand the factors that influence the development of family-therapist relationships and to explore suggestions for improving collaboration amongst families and OTs in the P4C model. Competing demands; consistency and availability; awareness, readiness and commitment; relationship with schools and educators; and sociodemographic factors all reportedly influenced the development of family-therapist relationships in P4C. The participants made suggestions to enhance interactions with families; however, further research is required that explores the family voice regarding ways to build strong family-therapist relationships. Ultimately, these relationships will improve knowledge transfer efforts in P4C and support children's participation at home, school and in the community.

Key findings

- Many factors influence therapists' ability to collaborate with families, including competing demands; consistency and availability; awareness, readiness and commitment; relationship with schools and educators; and sociodemographic factors.
- Innovative ideas are required for therapists and families to connect and build relationships, without increasing demands.
- Partnering for Change is a paradigm shift and parents, educators and therapists may need time, and support to adjust to this new model.

What the study has added

This study has provided a greater understanding of the factors that influence family-therapist relationships in Partnering for Change from the perspectives of OTs, and explores ways therapists can improve their relationships with families to support children's participation in both home and community settings.

Acknowledgements

The authors are grateful to the Ontario Ministries of Health and Long-Term Care and Education for funding this study and to the partners and stakeholders who provided leadership and funding of the health services and contributed to the research activities, in particular, the Central West and Hamilton Niagara Haldimand Brant Community Care Access Centres. The authors would also like to thank the health care decision makers,

educators and school communities, children and families, occupational therapists and team members who contributed to this study.

Research Ethics

Ethical approval was obtained in a letter dated April 25, 2013. REB #: 13-022

Consent

All participants provided written informed consent to participate in focus groups for the study.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This funding was supported by the Ontario Ministry of Health and Long-Term Care and the Ministry of Education (No. HLTC2972FL-2012-324).

Contributorship

Cheryl Missiuna, Nancy Pollock, Wenonah Campbell, Sandra Sahagian Whalen, and Leah Dix conceptualized and ran the research project of which this study was a part, developed the research protocol, applied for ethical approval, and organized data collection. Wenonah Campbell facilitated the focus groups. All authors contributed to the methodology of the project, and the analysis plan. Jennifer Kennedy completed the analysis, interpreted the findings and consulted the other authors throughout this process. Jennifer Kennedy wrote the first draft of the manuscript. All authors reviewed and edited the manuscript and approved the final version.

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Table 1. Overview of findings

Descriptive Categories	
Factors that influence the development of family-therapist relationships	**Suggestions for improving family-therapist relationships**
1. Competing demands 2. Consistency and availability 3. Awareness, readiness and commitment 4. Relationship with schools and educators 5. Sociodemographic factors	1. Face to face interactions 2. Increasing awareness of occupational therapy services

Chapter 4. The dance of family engagement in school-based occupational therapy: An interpretive description

This chapter presents an interpretive description study exploring families' and occupational therapists' experiences related to family engagement in school-based occupational therapy services and outlines the implications for practice.

Prepared for submission to: Canadian Journal of Occupational Therapy

The dance of family engagement in school-based occupational therapy: An interpretive description

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Abstract

Background: Family engagement is a central ideology in pediatric occupational therapy; however, the literature indicates that engaging families is challenging in the school-based context. **Purpose:** The purpose of this study is to explore occupational therapists' and families' experiences of family engagement in school-based occupational therapy services and to propose stakeholder-informed improvements to service delivery. **Method:** An interpretive description design was applied. Interviews were the primary method of data collection and were analyzed using inductive thematic analysis. **Findings:** Family engagement was depicted metaphorically as a group dance. The findings outline how therapists' and families' capabilities and expectations, trust, communication, emotional connections, and contextual factors interact to impact family engagement. **Implications:** Important changes to practice are required. Technology might enhance opportunities for connection and communication. The adoption of service delivery models that endorse a needs-based approach to service, rather than a 'one-size-fits-all' approach, are necessary to increase the value families place on this service.

Key Words: Parents, occupational therapy, qualitative research, parent-therapist relationship, school-based practice

Introduction

A main tenet of occupational therapy practice is ensuring client-centred care (Townsend et al., 2007). When working with children, occupational therapists acknowledge that the family has a major impact on children's ability to participate in their occupations and, as such, take a family-centred approach (Jaffe, Humphrey, & Case-Smith, 2010). Family-centred approaches acknowledge the expertise families have regarding their children, identify family members as essential members of the treatment team, tailor interventions to families' individual characteristics and needs, and design interventions focused on supporting family functioning overall (e.g., Dunn, 2011; Dunst, Trivette, & Hamby, 2007; Rosenbaum, King, Law, King, & Evans, 1998). Theoretically, family-centred care and family engagement in services are desirable because they have the potential to increase the impact of service by informing the therapist's understanding of the child, as well as increasing the family's capacity to generalize recommendations to support children in their home and in the community (Jaffe et al., 2010; MacKean, Thurston, & Scott, 2005; Rosenbaum et al., 1998). Despite the desire for all pediatric occupational therapy services to be family-centred, the practice setting substantially influences the degree of family-centredness, with school-based settings being less family-centred compared to home and clinic-based settings (Fingerhut et al., 2013). Regardless of setting, family engagement is a central ideology in pediatric occupational therapy; without it, occupational therapists cannot practice in a way that reflects the profession's core values (Jaffe et al., 2010). The aim of this study is to explore occupational therapists' and families' experiences of family engagement in school-based occupational therapy

(SBOT) services in order to generate stakeholder-informed improvements to service delivery.

Background

Occupational therapists have delivered school-based services in Ontario, Canada since 1984, and serve approximately 35 000 students each year (Deloitte & Touche, 2010). The purpose of providing services in the school setting, rather than a clinic setting, is to ensure school-aged children are not denied access to education when they have specific health needs and to increase access to services for families with geographical or transportation barriers (Deloitte & Touche, 2010; Malatest & Associates Ltd., 2014). However, despite the increase in access to education and health care services, the context of school-based services creates inherent challenges in providing family-centred care (D'Arrigo et al., 2019; Fingerhut et al., 2013; Kennedy et al., 2020a).

D'Arrigo and colleagues (2019) used qualitative methods to explore parent engagement and disengagement in pediatric occupational therapy settings (e.g., hospital, community, education, private practice) in Australia. In their study, school-based occupational therapists reported that the focus of practice was primarily to support educators, which left little time for parent engagement. This limited scope presented an internal conflict for therapists who reportedly valued family-centred care. Additionally, these therapists indicated that they had a difficult time knowing whether a parent was engaged or not because they did not have many in-person interactions. Overall, D'Arrigo et al. (2019) highlighted some of the challenges related to family engagement in school-based services; however, due to the study's breadth across all pediatric settings, in-depth

findings specific to the school setting were not available. Moreover, the parent voice was not included.

A grounded theory study by Fingerhut et al. (2013) explored the phenomenon of family-centred care by interviewing 28 occupational therapists working in a variety of pediatric settings in the United States. The findings indicated that home-based practice is the most family-centred, and school-based practice is the least family-centred. School-based occupational therapists reported that they rarely communicated with families, although it varied from family to family. Occupational therapists working in the school setting were able to identify many family-centred care principles, such as parents being a part of the team, but no school-based therapists described their practice as family-centred. Moreover, while they acknowledged family-centred care as being critical to the child's quality of life, they indicated that the school setting created many barriers to providing this type of service. Barriers to family-centred care were discussed but it was unclear which barriers were specific to school-based settings. The authors surmised that providing family-centred care was not an expectation of SBOT service, which limited occupational therapists' efforts with families. This study provided insight into some reasons school-based occupational therapists may find it more challenging to provide family-centred service but, again, the broad nature of the study, and the lack of parent voice, limits the depth of understanding.

A qualitative description study by Kennedy et al. (2020a) explored occupational therapists' perspectives of family-therapist relationships in a unique service delivery model, Partnering for Change (P4C) in Ontario, Canada. P4C is a school-based model

designed to promote collaboration amongst parents, therapists, and educators (Missiuna et al., 2015). Unfortunately, even in a model designed for collaboration, therapists still reported difficulties connecting with families. Factors that they believed had influenced the development of family-therapist relationships included therapists' and families' competing demands; the families' awareness of, readiness for, and commitment to services; the therapists' relationships with school and educators; and various sociodemographic factors (Kennedy et al., 2020a). This study highlighted some of the potential factors that may influence family engagement in SBOT services, but it was specific to a service delivery model that is not currently reflective of mainstream practice and was limited to the perspectives of occupational therapists. Typically, in Ontario, occupational therapists working in schools are contractors who see children individually and receive payment for each visit. Some occupational therapists are salaried employees of school boards, but this is not the norm. The P4C study presents an innovative model, but unfortunately it does not reflect the current context of SBOT.

Overall, the literature indicates that family engagement is challenging in the school-based context. However, an in-depth analysis of family engagement specific to typical delivery of school-based services, and the inclusion of the family's perspective is lacking. The existing literature highlights the challenges but does not inform occupational therapists about ways to support families in this context. This study aims to answer the following research questions: 1) How do families and therapists engage in children's SBOT services; 2) What influences their engagement; and, 3) What strategies do parents

and occupational therapists suggest to improve engagement and collaboration between parents and therapists in SBOT services?

Methods

Research design

This study employed an interpretative description methodology. Interpretive description is a qualitative approach used to address a discipline-specific clinical phenomenon (Thorne, Reimer Kirkham, & O'Flynn-McGee, 2004). With a focus on answering applied clinical questions that originate 'from the field,' the end goal of interpretive description is to inform clinical understanding (Thorne, 2016). In this study, the research questions were developed from the applied health discipline of occupational therapy and have a goal of informing occupational therapy practice; therefore, interpretive description was selected as the most appropriate qualitative approach. Ethics approval for this study was received from the McMaster University Hamilton Integrated Research Ethics Board (HiREB Project #5455).

Disciplinary orientation

It is important to make one's disciplinary orientation explicit in interpretive description studies because this orientation inevitably shapes the researcher's thought process, decisions, and final research product (Thorne, 2016). The primary researcher (JK) is a trained occupational therapist who has clinical experience working in SBOT services. In practice, the primary researcher has encountered many barriers to building relationships with families and is motivated to find possible solutions to address this

practice issue. The clinical experiences of the primary researcher provided the initial scaffolds of this study.

Sampling and recruitment

Purposive and snowball sampling were sampling strategies used in this study (Creswell, 2013; Gentles, Charles, Ploeg, & McKibbon, 2015). In purposive sampling, the researcher focuses on specific groups of individuals that could provide relevant information to answer the research questions (Creswell, 2013). In order to identify participants who were information-rich, occupational therapists who deliver SBOT services and family members of children who had received SBOT services were invited to participate. Snowball sampling refers to when individuals who know about the study introduce the study to individuals who they think would be information-rich (Creswell, 2013). Both purposive sampling and snowball sampling led to recruitment of participants in this study.

School-based occupational therapists were recruited through the Ontario Society of Occupational Therapists (OSOT) and OSOT's school-based community of practice. The primary researcher contacted OSOT via email and paid a fee for OSOT to post the recruitment call to their website, and to email all school-based OSOT members who had consented to receive research recruitment correspondence. Additionally, an email was sent to the leader of OSOT's school-based community of practice requesting that she forward the recruitment information to the community of practice. An email was also sent to the program directors of local service provider agencies and children's treatment centres which are contracted to provide SBOT services in their regions within Ontario.

For agencies that agreed to participate, agency-specific ethical approvals were sought prior to initiating recruitment. The occupational therapist participants may have received the recruitment call from multiple avenues; therefore, it is difficult to know which strategy resulted in successful recruitment.

Occupational therapists who worked within differing remuneration models (e.g., fee for service, salary) and who had varying years of experience were recruited. Occupational therapist participants were required to have at least six months experience delivering school-based services in Ontario (to ensure they had experienced the phenomenon adequately), the ability to communicate in English, be willing to complete a 60-90 minute interview, and to provide informed consent.

The recruitment of family participants mainly occurred through snowball sampling. Family members of children who had received SBOT services were recruited through several sources, including the primary researcher asking participating therapists to provide parents who they believed might be interested in participating in the study with a parent information letter. The therapists were also provided with a script to introduce the study to potential parent participants. This letter outlined relevant information about the study and the primary researcher's contact information. This same letter was also posted on private Facebook groups for parents of children with disabilities. Lastly, family members who participated in the study were encouraged to share the study information with their networks.

Family members were required to be the legal guardian of a child who had received SBOT services in Ontario within the past two years. Family members also

needed to be able to communicate in English, complete a 60-90 minute interview, and provide informed consent. All participants provided written informed consent to participate in the study, and were provided with a $25 gift card honorarium.

Sample

Ten family members and six school-based occupational therapists participated in the study. The family members included 10 mothers from across Ontario. They varied by location, primary language spoken, family composition (i.e., number of children in the family), family characteristics (e.g., foster or biological parents), educational background, main occupational focus, income level, and physical and mental health statuses. Two families identified that they primarily spoke languages other than English at home. Two families had only one child, and all other families had more than one. One parent identified as a foster mother; all others identified a biological relationship with the child. Most participants had completed some form of post-secondary education, except for two who reported having a high school education. The majority of participants identified that their main occupational focus was either caring for their family, or working part-time, with two participants working full-time, and one on maternity leave (from working full-time). Household income ranged from $20 000-39 999/year to over $100 000/year, with most between $60 000 – 79 999/year. Physical health status ranged from 'well enough' to 'very well,' and mental health status ranged from 'not very well' to 'very well.' Additionally, some were parents of multiple children with complex care needs, and others were parents of one child with less complex needs. The children who received occupational therapy services had a range of diagnoses including: cerebral palsy, speech

language impairment, Down syndrome, autism spectrum disorder, learning disorder, attention deficit hyperactivity disorder, visual impairment, global developmental delay, depression, anxiety, and other genetic disorders.

The six occupational therapists had between 3 and 36 years of practice overall and in school-based practice. Three occupational therapists were employed by service provider organizations and were contract workers paid in a fee-for-service model, and the other three were salaried employees of a school board.

Data collection and management

Semi-structured one-to-one interviews were the primary method of data collection. Preliminary interview guides were developed for both sets of participants, families and occupational therapists. The preliminary interview guide for family members was developed in consultation with three parents who are members of the *CanChild*'s Parents Partnering in Research Facebook group. *CanChild* is a research centre at McMaster University committed to generating knowledge and improving the lives of children with developmental conditions and their families. The preliminary interview guide for occupational therapists was developed with consultation from researchers and clinicians with school-based expertise. Interview questions were open-ended to allow the participants to explain their answers and provide richness in their responses. Examples of interview questions were, "How would you describe your participation and engagement in your child's occupational therapy services in the school setting?" (family members) and "How do most parents engage in children's SBOT services?" (therapists). Modifications to the interview guide were made throughout the data collection process to

explore areas of emerging interest in greater depth. This process facilitated further discussion, substantiation, and clarification of initial findings. All interviews were conducted and audio recorded by the primary researcher. Interviews were completed at a location chosen by the participants (private room at McMaster University, their home, or their workplace). Interviews ranged from 42 – 90 minutes in length. Additionally, the participants filled out a demographic survey to gather descriptive information. All interviews were transcribed verbatim by an experienced transcriptionist. All data pertaining to the study was anonymized using a unique identifier code for each participant.

Data analysis

Data analysis was completed using inductive thematic analysis (Braun & Clarke, 2006). An inductive approach means the development of codes and themes is data-driven rather than driven by pre-existing theory (Braun & Clarke, 2006). The analytic process progressed from the development and application of descriptive codes, to themes that go beyond the statements made by the participants and then to a higher level of interpretation.

Congruent with phase one of thematic analysis, *familiarizing yourself with your data*, the primary researcher read through the transcripts multiple times to immerse herself in the data (Braun & Clarke, 2006). Creating memos while reading through the transcripts captured initial thoughts and ideas. The primary researcher began to notice patterns and potential areas for further inquiry following the first few interviews. At this time, she engaged in phase two of thematic analysis, *generating initial codes,* by creating

a preliminary codebook with codes based on early patterns in the data (Braun & Clarke, 2006). The codes in the codebook were also informed by the clinical experiences of the primary researcher, which is referred to as *scaffolding* in interpretive description methodology (Thorne, 2016). As an initial test of the codebook, two members of the research team (JK and ST) applied the preliminary codebook to the first four interview transcripts. The researchers met to review each other's application of the codebook and discuss relevant modifications. Although this process facilitated refinement of the codebook, it continued to evolve iteratively throughout data analysis.

Phases three and four of thematic analysis, *searching for themes* and *reviewing themes*, were completed using NVivo 11 (QSR International, 2018) software, and by diagramming and doing visual mapping in a separate notebook (Bazeley, 2013; Braun & Clarke, 2006). These phases resulted in the development of preliminary themes, then more finalized themes with an enhanced understanding of how these themes related to each other. *Defining and naming themes*, phase five, consisted of theme refinement, and the identification of the story of each theme. Finally, phase six of thematic analysis involved *producing the report* and including sufficient evidence of the themes within the data (Braun & Clarke, 2006).

Rigour

Triangulation of data sources is highly recommended by Thorne (2016) to enhance the overall credibility of the findings. Using interviews from two groups of participants (families and occupational therapists) is a form of data source triangulation that contributes to a better understanding of the phenomenon and validation of the

findings (Creswell, 2013). Additionally, Thorne (2016) specifically recommends the use of "thoughtful practitioners" (p. 92) to provide expert opinions on the phenomenon after having experienced many cases of the phenomenon over time. In this study, the occupational therapist participants filled the thoughtful practitioner role as they have experienced the phenomenon across multiple families, schools, and in some cases across various service delivery models. This provides the researcher with an insider perspective of the phenomenon across time and contexts and helps to advance the richness of the data (Thorne, 2016).

In interpretive description, the researcher is seen as a co-constructor of the data (Thorne, 2016). To enhance the quality of data that is constructed throughout the interviews, the researcher must reflect on previous clinical and personal experiences, and on how time spent reviewing the literature may have an influence on the data (Thorne, 2016). Thorne (2016) suggested using a reflexive journal to record "theoretical allegiances, your expert clinical opinion and other sources of prior knowledge" (p.119) to better understand the implications of the researcher's role in data collection and construction. The primary researcher maintained a notebook to record initial thoughts following each interview, reflective memos, analytical thoughts, questions and initial interpretations. Additionally, the primary researcher engaged in reflexivity through use of reflexive journaling in an effort to enhance credibility and trustworthiness (Bazeley, 2013). Finally, to limit bias and promote confirmability and investigator triangulation, the primary researcher reviewed the findings and engaged in analytical debriefing with

experts in the field, and members of her doctoral supervisor's research team (Lincoln & Guba, 1985).

Findings

The participants described family engagement in SBOT services in a way that can be represented metaphorically as a group dance. The idea for this metaphor first emerged when one participant used dance as a metaphor for explaining how parents need opportunities to engage in ways that work for their individual learning needs. She was a trained dancer and explained how dancers all have different learning styles and approach the way they learn and memorize choreography differently. From there, the metaphor developed and evolved to become a useful way to organize and illustrate the findings.

The essential elements of the dance that illustrate family engagement in SBOT services are: the **dancers** (the family, the occupational therapist, the school staff), the **choreography** (the actions of the family, occupational therapist, and the school staff in supporting the child), and the **music** (the context of the service). Developing from these essential elements is the overall dance performance. How impactful the performance of family engagement in SBOT services is depends on the **trust** and **communication** between the dancers, as well as each dancer's individual **skills**, **resources**, **expectations**, and the **emotional connection** the dancer has with the dance itself. The **contextual factors** also influence the overall performance. This metaphor will be used to demonstrate how families and therapists engage in SBOT services and what influences their engagement.

Dancers

"An interaction between schools, parents, OTs, that's, for me, the core of it (16P)". Rather than a solo or duet, family engagement was seen as a 'group dance', involving multiple dancers. The participants proposed that family engagement involves more than just the family; it involves multiple parties including: the family, the occupational therapist, the educators and other school staff (e.g., classroom educators, educational assistants, special education resource teachers, school administrators, etc.). This is an important finding for understanding *who* has the potential to influence family engagement, and the overall experience of SBOT services, and most importantly, *who* is responsible for supporting the child.

> I've always held in such high regard a team approach. If you only have one team player, that's not a team, right? So, to me, it's extremely important…to have all the team pieces together (8P).

Although the child was not described as an active participant in family engagement, they were described as the primary focus of family engagement.

> …it is about the relationship between school and our service and family and how we can maximize that in terms of the support that we offer to the student and to the family. You know, our primary focus is a student… (2OT).

Beyond *who* is involved in family engagement, the participants also described the actions taken by the families and occupational therapists, and the contributions made by school staff in the process of family engagement to support the child. These actions and contributions are the *choreography* of the dance; the moves each dancer makes.

Choreography

In the case of family engagement in SBOT services, the moves that each dancer makes are established without any upfront discussions, or set choreography. There is no particular choreographer to design roles that are appropriate for each dancer in terms of their skills and abilities. Rather, the choreography is more interpretive in nature, where the dancers themselves decide which moves to make. The moves each dancer makes represent the roles that are taken on by each participant in terms of family engagement in SBOT services. The moves they decide to make are shaped by individual *skills*, available *resources*, their *expectations* of other dancers, as well as the *trust* between the dancers, and their ability to *communicate* effectively with each other.

Roles: The moves dancers make. Each participant discussed the roles of the family, the occupational therapist, and the school staff in family engagement in SBOT services. The roles of the specific groups (families, occupational therapists, and the school staff) seemed to be undefined with respect to what each group should do to best support the child, which sometimes led to confusion and unmet expectations regarding the responsibilities of each group. There was often a discrepancy between the roles one group expected another group to take on, and what the group actually does in practice. For example, family members often expected the occupational therapists to connect with other service providers in the community, but reported this did not always happen. It was evident that an individual's *skills* and *resources* shape the type of roles they ultimately take on.

Family. The participants outlined many roles that families assume in the process of family engagement in SBOT services. Some examples that were commonly discussed include being: advocates, collaborators, communicators, implementers, managers, problem solvers, and researchers. Families reported that they needed to take on these roles to ensure their child was supported at school. They explained that they needed to be "strategic" (16P) about their actions. "It's like you almost have to be a politician or a chameleon, in terms of you have to know who your audience is" (4P). It is evident that some of the families in this study were taking on highly complex roles because they believed that these roles were imperative to their child's success, and they had the skills and resources (i.e., time) to do so. However, it was acknowledged that not all families who receive SBOT services would have the capability of taking on these roles, and therefore, it should not be an expectation or requirement. One family participant stated:

> Again, I think some families are maybe just so busy putting bread on the table, they don't even have time to notice the issues. And even if they do, they have no time to address some of them because they are working two jobs and they need to sleep … Parents want the best for their kids like you do… to set children up for success, you have to set the parents set up for success… I think the way things are, parents are undermined, which then undermines the children and it just keeps going. (16P)

Many of the occupational therapists acknowledged this issue as well.

> I do think that most parents are engaged to the extent that they can be. So you're still going to get those parents who are just struggling to get the kids to school and then they have to get off to work or whatever, and you know, make sure there's food on the table…And even though those parents don't appear engaged because they're not calling you, they can still be just as engaged with the benefit of the child. It just looks differently. So I think we have to recognize that too. (3OT)

Many family participants acknowledged that they were only able to engage in the service because they were not working, or only working part-time. One parent who was

on maternity leave stated, “like I said, this is not a normal scenario. I’m just extremely proactive. I have the time” (4P). Only one parent in this study reported working full-time; however, this parent was self-employed, which reportedly provided flexibility. “Well, because I’m self-employed, I can choose where to allocate my time” (10P). Occupational therapists also acknowledged that the family’s time was an important factor in engagement in services. “I think that’s probably one of the biggest factors that, for those families who want to be engaged but who maybe just don’t have the time” (11OT).

To summarize, the participants acknowledged that there are many different roles that family members take on when engaging in SBOT services. However, each family is going to engage in ways that ultimately depend on the family’s skills, resources, and overall capabilities. The participants highlighted that not all families have the capacity to assume some of these roles, and this needs to be taken into consideration when setting expectations for the service.

> A lot of the time, I think parents are just worn out. You know, parents of kids with special needs--who are kind of the primary focus of our service--have a lot on their plate and I think that sometimes just one more person to talk to is, you know, it’s just impossible for them. (2OT)

Occupational Therapist. When discussing the roles of the occupational therapist, the participants indicated that occupational therapists take on a variety of roles, including being a(n): communicator, collaborator, coordinator, educator, encourager, expert, goal-setter, initiator, manager, and professional. Both family and occupational therapist participants identified the importance of these roles in supporting family engagement.

> Find out what might work. Try a few things. If it doesn’t work, try something different. But let us know what she thinks, and help us to do what we can. And follow up with us and say, you know, is this working? (7P)

The participants also indicated occupational therapists should be approachable, transparent about their services, and flexible in their approaches. One family member stated: "being approachable [is] definitely [an] easy way for the OT to engage parents I think." (9P)

In addition to the roles occupational therapists assume, the participants spoke about their overall capabilities and skills as therapists. Some family participants had the unfortunate experience of having multiple school-based occupational therapists for their child, due to high turnover. As a result, some of these parents experienced service from different therapists and highlighted differences in skill level, which impacted their engagement.

> And so here you have an OT who comes in, who's just doing the same program that you did for the last 20 kids, but maybe one had Down syndrome, and one had a learning disability, and one had CP, and now there's this kid with complex issues, right. So because you're not furthering your education, taking advantage of any workshops or you know, certifications and different tools that you could use, here she is setting this kid up for failure. (8P)

Generally, families have expectations for the roles that occupational therapists should take on. However, these roles are inconsistently assumed by occupational therapists depending on their ability, which could be due to their personal skillset or due to a lack of resources.

> And then I think there's resources we need, like time, and what our caseloads look like. I think all of that affects our ability to support families to be engaged. (1OT)

School Staff. The participants suggested that the roles of the school staff also have important implications for supporting family engagement. The school staff includes educators, educational assistants, special education resource teachers, school

administrators, etc. Compared to the family and occupational therapist groups, there was less discussion about the impact of individual skills, or available resources in fulfilling school staff roles. Instead, participants mostly described the roles that the school staff assumed. The identified educator roles included being collaborators, communicators, coordinators, implementers, informers and supporters.

Educators were identified as a key component of family engagement because they are often the first to inform the family about the need for occupational therapy services, and they also facilitate communication and connection between the family and the therapist by sending notes home from the occupational therapist. Educational assistants help to implement strategies that are decided upon by the team and provide feedback on the impact of the strategies. Special education resource teachers (SERTs) and administrators support family engagement by coordinating meetings with the families and therapists, accessing resources for the child, and ensuring that educators in the classroom feel supported.

> And then the leadership of the like SERT or the program support teachers. So they're the ones that would kind of submit our recommendation letters, follow through on any equipment needs, if there's any like training that needs to be done for staff, like they're the ones that are coordinating that. So they're kind of like the coordinators, and between the family too. (5OT)

When considering all of the roles that the family, occupational therapist, and the school staff take on, it is often difficult to know who is responsible for which roles. Roles are reportedly not typically discussed at the beginning of service, so each group is unaware of the expectations of the other group with regards to roles and responsibilities. As a result, there can be a mismatch between the roles individuals are expected to take on,

and their actual ability to do so. The participants suggested that the team engage in a negotiation at the beginning of services to ensure each individual's role matches their personal capabilities, and is feasible given the individual's available resources. This negotiation would allow the team to establish expectations for each other's roles and the service overall. Therefore, instead of having a designated choreographer who dictates the moves made by each performer, or just letting the roles develop organically, such as in interpretive dance (the current state of family engagement in SBOT services), the roles of each dancer should be a negotiated process based on each dancer's overall capability.

Trust. Another factor that shapes the overall choreography, and each dancer's moves, is trust between dancers. Family participants suggested an interesting link between their level of engagement and the trust they had in their child's occupational therapist. Some families mentioned that they felt that they needed to be *more* engaged than they wanted to be based on their lack of trust with their therapist.

> Because it's basically a stranger coming to tell you what your child needs. And I don't trust that… if my OT from the children's treatment centre went into the school, I wouldn't have to be engaged to the level that I was. I trust her because she's been with us for almost five years. I would say, okay, just let me know what you decide. Like I said, trust is huge…I wouldn't have to be there all the time. (4P)

Families reported that they needed to take on roles, such as being a 'micromanager', to ensure their child was adequately supported at school. They stepped into these roles because they did not trust others to do so. Some families felt strongly that there was discrepancy between what the family's role currently is, and what it should be.

> So, my role has turned into very much micromanaging and communicating between therapists and I don't think that should be my role. I think my role should be bringing information from home and making sure that what's happening at

> school is supporting home and what's happening at home can support school. (12P)

Interestingly, other families who reportedly had high levels of trust with their therapists also reported a high level of engagement. The difference between these two groups of highly engaged families, was having the opportunity to *choose* the roles they wanted to fulfill, rather than fulfilling them out of the belief that their child would not otherwise be adequately supported.

> So, that one year of having that really great OT. She was awesome… And she was at every team-based meeting for him, she would go to bat for him with the administration, she would work collaboratively with the speech path, and with the [educational assistant], and [child and youth worker] You know, we'd have a team-based meeting and she would like then pull me aside after the meeting, and she and I would sit there and talk, you know…so she would have those kind of side meetings with me. It made me feel way more confident in what was happening in the school, because I knew she was so hands-on with him. (8P)

Therapists also acknowledged the importance of establishing trust and how this impacts the choices that families make regarding their engagement.

> So there can be a lot of fear because there's a lot of misinformation, but I do think that most parents, once they build trust with me as a clinician, then they engage by, you know, however they want to. (3OT)

Evidently, trust between families and therapists seemed to influence families' actions and the roles they assumed. Families' sense of agency seemed to be based on their feelings of trust, and had a profound impact on the families' overall experience with the service. These findings highlight the importance of establishing a trusting relationship near the beginning of services and ensuring that families have choice in the level of intensity of their engagement and the roles they take on. In addition to trust, communication also was noted to be essential to family engagement.

Communication. The final factor that helped shape the choreography was communication. Participants discussed the importance of communication in fulfilling their roles, and ensuring the child was appropriately supported.

With regards to family-therapist communication, the primary method of communication identified by the participants was handwritten notes sent home by the therapist after each visit with the child. Communication by phone calls or in person meetings also might take place, but this was reportedly secondary to the handwritten notes. Some occupational therapists indicated they would engage in emailing, but others stated this was against their college regulations. Most of the families indicated that email is the easiest, and most convenient, way for them to communicate.

> Email is easiest to communicate with because it's convenient. You can do it whenever you want, all hours of the night. Nobody really cares--you know, that kind of thing. You don't have to touch base, you don't have to both be available. But that was not an option in my situation. (6P)

It is important to note that the participants acknowledged the privacy concerns related to technology and communication of personal health information; however, families noted that the convenience outweighed the risk. The occupational therapists felt that "with all of this telemedicine that's starting… we would hope that somewhere along the lines we could make these avenues confidential" (5OT).

Generally, occupational therapists and families acknowledged the importance of having opportunities for 'dynamic communication', such as phone calls or in person meetings. They indicated that back-and-forth communication supports family engagement by allowing families to ask clarifying questions.

> So a phone call allows for the dynamic communication… Whereas if like a note…what if you have some questions, what if you don't understand what that means. (4P)

Although phone calls allow for dynamic communication, unfortunately, there was reported difficulty connecting with each other on the phone. In the current funding model, occupational therapists are often travelling from school to school during the day, and the phone number provided to the families is typically an extension that goes directly to a voicemail. As a result, there is no opportunity for the family to call and connect with the occupational therapist without first leaving a voicemail and waiting for the therapist to call them back. This creates a challenge because occupational therapists reportedly assume families will call them if they have questions, but some families reported the effort is not worth their time if they will only ever reach a voicemail.

> So, I called the OT, went to voicemail. So, I called the agency that he works for, went to voicemail. Got a call back from the agency saying, 'Well, they're private contractors. We don't know what their schedules are.' And the next thing I know I get a call from the school saying, 'The OT got here 5 minutes ago, are you able to come?' (12P)

Family participants reported that they wanted to be able to connect with the therapists if needed, but thought it was the therapist's role to check in periodically, rather than leaving that up to them.

> I do initiate phone calls and emails with people, with services. I do do that. I don't always like to do that because I feel like it should sometimes come from the service provider. However, if I feel like too much time has passed, and no one's connected, I would reach out. (9P)

Instead of taking on the role of initiating communication, family participants reported that it is their responsibility to "clos[e] the communication loop" (8P) when the therapist does reach out to them.

Interestingly, many of the occupational therapists reported feelings of guilt after describing their communication methods with families. Many therapists indicated that they could be doing more to connect with families.

> I think you can always be better. I mean, definitely I could be reaching out to them more often. So this family that I called yesterday, I had a bunch of things I had to ask her about. And as we were ending the conversation, she said to me, you know, call me anytime, anytime just call me. And I thought ah, I should call, like I should probably make a point of just calling parents. (3OT)

Both occupational therapists and families valued dynamic communication, and therapists reported they could be doing more to initiate this communication with families. Other suggestions were discussed for improving communication including offering options for communication methods at the beginning of service (e.g., email, phone, meetings, notes home) to best suit each family's needs. This way, families could choose what methods work best for their personal circumstances. Another suggested idea was to offer dynamic communication methods at the beginning of service to support the establishment of rapport. Ideas included offering video chats, teleconferences, or in-person meetings at the beginning of the service. "We can do a conference call or a video call, whatever… there's just so many easy…ways that people can communicate." (13P) Overall, the participants indicated that increasing the frequency of communication attempts made by therapists, and making communication more convenient, might help support family engagement by ensuring there are multiple opportunities for dynamic communication.

In addition to the influence of skills, resources, expectations, trust, and communication on the moves each dancer makes, the choreography of the dance also

depends on the music. The music in this study represents the context of family engagement.

Music

The music sets the tone for the dance, and elicits emotions, which impact how the dancers move. The type of dance chosen is dependent on the music, and the emotional connection the dancers have with the music is important to the overall performance. The music of the dance represents the contextual factors that influence family engagement in SBOT services.

In this study, participants spoke at great length about the contextual factors that influenced family engagement. In particular, there was much discussion about how *school factors* (i.e., the culture and the policies of each school), and *service factors* (i.e., the service delivery model) influence family engagement. Importantly, the *emotional connection* families had with the service also influenced their actions and overall satisfaction with the service.

School factors. Both family and occupational therapist participants noted that the school played an important factor in family engagement. The culture of the school has an important impact on how welcomed and respected families feel, and this feeling reportedly impacts their engagement in occupational therapy service as well.

> It's a culture of some kind where parents feel, you know, welcomed and acknowledged and respected, and feel that they're understood and that their voice matters, and that they're not just complainers and they're not just making unrealistic demands, and they're not just you know, perceived as not understanding their child and how do they think this is going to happen. It really varies from school to school how that might be received. (2OT)

Beyond the culture of the school, some schools seemed to have policies around parents attending the school and occupational therapy sessions, whereas others did not. Some families reported attending the school regularly, and others reported not being allowed to attend the school.

> Our principal that we have right now is very black and white when it comes to policies. And so for me to come in and participate in any type of OT program…he wouldn't allow that to happen. The previous principal that we had, I could do just about anything and he would say come on in. (8P)

Participants identified the principal as being the most influential factor in determining what family engagement might look like.

> But it also varies quite a bit from school to school, depending on--like I find it incredible how the principal seems to be able to create a culture in the school. And the principals, when they are able to create a culture of engagement, then parents seem to be much more engaged in all the services. (3OT)

It was clear from the participants' responses that the principal, the policies enacted by the principal, and the overall school culture influenced how families engaged with the school and with occupational therapy services.

Service factors. Participants noted that the location of the service, the type of service delivery model, and the availability of time had major implications for family engagement.

When families bring their child to clinic-based rehabilitation services there is an opportunity to build relationships and improve family engagement. This does not happen as naturally in the school setting.

> But I know from my own experience doing like in-centre and school stuff, the level of engagement is significantly higher when … parents are coming in…You are able to explain like in real time what you're doing as you're doing it. I think parent engagement is kind of affected by they don't see what we're doing (1OT)

In addition to having less opportunity for face-to-face interactions, there also is confusion around the policies related to having in-person meetings. In some cases, parents were not sure if they were even allowed to come in to watch a session or meet with the therapist.

> I bet if I asked to come in and observe a session or two, it would probably be something that they could accommodate. But it's never been asked. I've never asked and they've never offered. (7P)

Another service-related factor is the type of service delivery model. Two types of service delivery models outlined by the participants seemed to be based on the remuneration methods of the organization employing the occupational therapist. Some participants described a per-visit or fee-for-service model where the therapists were paid for each visit made to see the child. Any additional administration or communication time is to be covered by the visit fee, but this model reportedly impacted how motivated therapists were to spend the time to connect with families.

> Within the per-visit model it was rare to have the parents highly engaged 'cause all you get is one visit to meet with them and most parents didn't even meet. And maybe you could try to have a phone conversation. But although I did have a few parents who did try to have hour-long phone conversations with me when – when you're on a per-visit model, that really eats up a lot of time. (11OT)

In the per-visit model, the therapist typically provides a block of service (e.g., six visits), depending on the needs of the child. Families reported that the short block of service does not provide adequate time for the therapist to get to know the child or the family. In this type of model, families reported they often felt the need to fill in the gaps in service.

> When your OT only sees your kid a couple times a year, it's tricky. You don't really have much time to get to know anyone and what their needs are. So obviously, I have done the research probably before I talk to the OT, and I'll suggest oh, so he needs these scissors. (9P)

Additionally, there was reportedly a high turnover in the per-visit model with multiple families citing that their child received service from several different therapists in one school year. Some noted that they were not even sure if their child was still receiving occupational therapy services, or who their provider was. This led to concerns about continuity of care beyond the current school year. “There is no continuity of care. Like if she’s in SK getting, you know, a third OT, I’m concerned what’s happening in grade one, two, three, four” (4P).

The participants also discussed another service delivery model, an “all school” approach, where the therapist provided service to the entire school, rather than individual children specifically referred to occupational therapy services. In this model, the therapists analyze the needs of the school and may choose to work with whole classrooms, a group of children, or individual children, depending on needs. This type of service was noted to align with a salaried remuneration model. Although therapists felt that this type of model allowed for increased communication and connection with families, families were divided. One parent seemed dissatisfied with the service:

> Yeah, so she would have like five or six other schools that she’s responsible for as well…I think we had some communication in September…We haven’t had any other OT communication whatsoever. Like there’s not been phone calls, or a letter, or anything. (8P)

Whereas, another parent felt this service was really helpful:

> Like if I say can you show me, like can I come in and you show me what you mean. She’ll always make an appointment. It may not be this week, but two weeks away and we’re in there doing it, right. So I really like that--the OT’s specifically at her school, I don’t know what other schools they go to--but the OT that I’ve had since the school year started, she’s really great. (6P)

Occupational therapists indicated that engaging with families takes time, and in some service delivery models (i.e., when they are working in a fee-for-service structure) they are not necessarily paid for that time, which becomes an inherent barrier to family engagement.

> I often found that I wanted to spend the time, even if it was just a phone conversation, talking with the parent. As I said, sometimes I'd spend an hour talking with the parent but then I have to take my own time into account and if I spent an hour with every parent when I'm really only allotted, maybe, an extra 15 minutes or ½ hour per visit to do paperwork, then I'm spending a lot of my own time being unpaid, which I have the desire to want to help and I want to help the children but if I did that with every single child, then I'd have no time for anything and then I'm not being paid for any of my time. (11OT)

The parent participants also acknowledged the lack of time for occupational therapists to reach out to them.

> But to touch base with her immediately following and say like, how do you think she's doing. That kind of thing. But she doesn't have time for that. She's got all these kids. And a backlog of 500 million kids that need services. She doesn't have time to have that conversation with me afterwards. She probably barely has time to write that note for me. I've seen it. (7P)

The amount of time allotted to each child and family as part of the service seems to be a limiting factor for family engagement as well. One therapist noted that, due to the limited number of visits that she has with each child, she often chooses to forego family meetings because attending them takes momentum away from getting the child what they need in the classroom:

> Am I going to use a visit for meeting with the parents? I should. But now the school was like, let's go, let's go, let's go. We need equipment for this. Let's go. Like, we don't have time. Let's go, we need to get these things in place, right? (15OT)

Generally, it is evident from the participants' responses that family engagement takes time. One therapist mentioned:

> I remember this one family that I was working with. And I started counting up the number of meetings that we had with this particular child in this particular year, and I counted up the number of kids I had on my caseload. And I thought if I engaged with every family the way that I'm engaging with this family right now, I would have to work a hundred hours a week. (3OT)

Overall, participants reported that family engagement depended on the service context, including the location of service delivery, the service delivery model, and the availability of time within the service. The participants reported that family engagement requires time from the family, time from the occupational therapist, and it can really only be fostered with adequate service time dedicated specifically to connecting with families.

Both service delivery models discussed by the participants were consultation-based models and it was evident that most of the families had an emotional disconnect with consultation-based services. Their emotional connection to the service impacted their overall engagement.

Emotional Connection. As a dancer's emotional connection to the dance influences their performance, a family's emotional connection to the service influences their engagement in the service as well. "It just feels … what's that word? Institutionalized. Like it's just like robot work. We're going to go in and do this, and then it's off to the next" (13P).

Many family members suggested that they valued occupational therapy as a profession, but the current service was unable to meet the needs of their child due to the

general lack of OT support, and the type of support available (e.g., consultation).

Regarding frequency, one parent stated:

> Do I think that anything can be accomplished in one OT session a month? No. I don't. I really don't. So I don't know that that'd be worth it. I think we could do with one a week though, yes. But then that costs a lot of money. (9P)

Another parent suggested that the responsibility of the service falls to the families because the occupational therapists have so many other children to work with and they cannot adequately support children, given the current service model.

> Well, in my experience, it all falls on the parents…Some schools can be wonderful, teachers can be wonderful, OTs can be wonderful. But even when they are, they have many kids to work with. So, it's always completely the responsibility of the parents to teach them, to make sure things keep happening, to keep communicating, to keep moving forward, to make sure that things are still working. (16P)

The occupational therapists noted that some families did not value the type of support provided to their child.

> We have a consultative model…which I think a lot of parents just kind of - I don't know that parents can see a lot of the value in the consultative, because a lot of them seem a little bit upset. Like almost every parent asks, are you going to do one-to-one therapy? And we have to explain that our service model is consultative. So I think … they don't see kind of the work we're doing within the school. (1OT)

Families also reported that the lack of emotional connection with the current service delivery model impacted their engagement. "As I said, it's consultation only. So what am I going to participate in, right?" (8P). Another parent mentioned, "It really feels like ... not completely for show, because I do feel there are some benefits to the OT services, but it's very minimal" (16P).

Mostly, families seemed to value occupational therapy, but did not see the value in the way it was being delivered. The current levels of service frequency and the type of service delivery ultimately impacted their overall engagement. To ensure families feel that there is value in their engagement, they need to first believe that the service is valuable. As such, in terms of the dance of engagement, when families do not have an emotional connection to the music, or the type of dance they are expected to perform, there is a negative impact on overall performance.

Discussion

Using the metaphor of a dance, this study provides an interpretive analysis of how families and occupational therapists experience family engagement in SBOT services. The dance of family engagement demonstrates *how* families and occupational therapists and school staff currently engage, and *what* influences their engagement. In this discussion arguments related to the three essential features of family engagement are explored: the dancers, the choreography, and the music. Firstly, the actions of the dancers are discussed, and the need for **a team-based approach**. Family engagement depends on how the team functions together, not only on the actions of the family. In terms of choreography, there is a need for **role negotiation** to customize service, and meet the individualized needs of families, to improve family engagement. And, finally when considering the music and how it sets the stage for the dance, the impact of identified service factors on family engagement is explored, with recommendations for **service transformation**.

A team-based approach

Participants in this study discussed the importance of taking a team-based approach (families, occupational therapists and school staff), and stated that outcomes were better when everyone on the team worked together, rather than in silos. Participants suggested that family engagement is maximized when all stakeholders are engaged in the process; therefore, it can be argued that family engagement encompasses the actions of more than just the family.

Interestingly, authors of a recent systematic review reported that the primary means by which researchers measure parent engagement is by examining the behaviour of the parents only (D'Arrigo, Ziviani, Poulsen, Copley, & King, 2018). Behavioural engagement in the articles that they included was measured by attendance, adherence, and observations of the family member in the session (D'Arrigo et al., 2018). No measures in the study by D'Arrigo and colleagues (2018) considered the behaviours of the therapist, or other stakeholders, and the influence of these behaviours on family engagement. Although the results from this systematic review indicate current measures of parent engagement narrowly focus on examining the behaviours of the family alone, there are some studies that acknowledge the role of the therapist as well.

In a review examining the concept of engagement more broadly in healthcare and rehabilitation, researchers suggested that clinicians have an important role in establishing engagement with their clients (Bright, Kayes, Worrall, & McPherson, 2015). Specifically, Bright and colleagues (2015) proposed that clinicians engage in an invisible process of developing a trusting relationship with families and that this relationship impacts the

client's overall engagement. After synthesizing their findings, engagement was conceptualized as a "co-constructed process and state" (p.650), indicating an active role of the health care provider in facilitating the client's engagement (Bright et al., 2015). A qualitative study exploring occupational therapists' perspectives about parent engagement in the delivery of pediatric rehabilitation and developmental interventions also supported these findings (D'Arrigo et al., 2019). In that study, occupational therapists indicated the therapist's ability to be responsive to the needs of the parent, and the quality of the parent-therapist relationship, had a major impact on parent engagement.

Collectively, these studies support that family engagement is not based on the actions of the family alone. When looking at the education literature more broadly, the role of the school staff in family engagement is clear as well. Results of a concept analysis of family engagement in the educational literature indicates that educators and other school staff have a major impact on how welcomed families feel in the school environment and how likely they are to engage (Kennedy et al., 2020b). Additionally, the Theoretical Model of Parental Involvement, which outlines the factors that influence parental involvement in their child's education, demonstrates the importance of educator invitations for families to become involved (Hoover-Dempsey & Sandler, 1995; 1997). It is likely that educators also have a substantial role in contributing to the team process and the co-construction of family engagement in SBOT services.

As such, family engagement needs to be considered as a multi-faceted team process, rather than only considering the family's actions or inactions. Occupational therapists need to consider their own actions in how they support and enable families to

become engaged in services, and how they collaborate with educators to do the same. Future research is recommended that explores the role of educators and other school staff in family engagement in SBOT services in greater depth.

Role negotiation

Many of the family participants noted that they are engaging in SBOT services by taking on complex and cognitively demanding roles such as case managers, advocates, and service coordinators. Although some indicated that they *want* to assume these roles, others stated they do so because they feel like they have no choice. The lack of trust some families have in the system, service, and sometimes the occupational therapist, motivates families to take on these roles to ensure their child is supported. This is an issue of equity because many families are unable to take these roles on for a variety of reasons, and if no one assumes these essential roles, children will be further disadvantaged. Instead, occupational therapists who are trained to undertake these roles should take responsibility. Acknowledging that some families will want to continue to engage in this way, an argument can be made for the need for role negotiation to customize service, to meet the individualized needs of families, and to improve family engagement.

Other researchers have presented similar findings. In an institutional ethnography studying advocacy in the context of school-based support for children with disabilities, researchers found that school-based practitioners often used parents as proxies in their advocacy work (Ng et al., 2015). In this study, practitioners were noted to provide parents with healthcare documents to help parents advocate for their child, rather than communicating directly with the school staff. The researchers noted that parents were not

always in favor of assuming the advocate role. Privacy legislation and time were some reasons healthcare practitioners relied on parents as proxies rather than assuming the role of the advocate themselves; however, the researchers highlighted the need for school-based practitioners to be sensitive to times when parents are not well-positioned to advocate for their child. Ng and colleagues (2015) suggest the need for further research investigating the ethical implications of caregiver burden.

To reduce the potential for caregiver burden, occupational therapists should engage families, and potentially educators, in a conversation before services begin to negotiate and establish each team member's role. This initial conversation around role determination also might be an opportunity to discuss families' expectations regarding what the service entails, and what the therapist can offer in this setting. A recent study on parents' expectations in children's rehabilitation services outlines the importance of explicitly discussing parent expectations for service delivery at the outset, and throughout service, as a way to improve family-centred care and collaboration with families (Phoenix, Smart, & King, 2019). Not only would this provide therapists with an opportunity to manage expectations, but it also may facilitate development of the family-therapist relationship. Therefore, it is recommended that school-based occupational therapists engage in conversations with families at the beginning of service to discuss and manage expectations and provide choice in roles for families to engage in ways that are meaningful for them, as a strategy to optimize family engagement. Ultimately, the therapist is responsible for coordinating the choreography of all of the dancers, but the

individual dancers will need to discuss and negotiate the choreography that they personally engage in based on their individual needs and preferences.

A service transformation

From the participants' responses, it was evident that some families do not see the value in SBOT services, in their current form. The participants reported that current services have limitations regarding the available time for therapists and families to connect, as well as the type and frequency of communication methods that are accepted in practice. Additionally, some families reported that SBOT service in its current form is not meeting the needs of their children. The number of sessions is typically prescribed by the funder rather than allowing therapists to use clinical reasoning skills to determine need and frequency of service. Based on the perspectives of both the therapists and the families in this study, we argue that there is a need for a service transformation. The new service should support protected, and funded, time for families and therapists to connect, flexibility in communication methods (e.g., video conferencing, mobile application), and permit therapists to use clinical reasoning skills to determine service frequency and duration. These changes would be expected to lead to a more positive experience for families by increasing the emotional connection with the therapist and service.

Time is a major limitation in the development of meaningful and trusting relationships between families and occupational therapists in SBOT services (D'Arrigo et al., 2019; Fingerhut et al., 2013; Kennedy, et al., 2020a). Currently, most occupational therapists in Ontario working in a fee-for-service model are not paid for their time to communicate and collaborate with families and other service providers. Ensuring

therapists have protected time to connect with families would demonstrate the value of collaborating with the family, and would allow for increased motivation and time to build trusting relationships, which has been shown to be the foundation of engagement (Bright et al., 2015; D'Arrigo et al., 2019). In addition, more flexible means of communication are required to meet the needs of families and to promote increased opportunities for dynamic communication between families and therapists.

To ensure the child is adequately supported across both home and school environments, effective communication between the adults supporting the child is imperative. However, participants noted that frequent and consistent communication between therapists and families is not always feasible in school-based services. This finding is corroborated by other studies involving family engagement in SBOT practices (Fingerhut et al., 2013; Kennedy, et al., 2020a). Electronic technology may be beneficial in bridging the communication gap in this setting. By incorporating technology for communication between families and service providers, studies from a variety of disciplines have shown success in increased parental engagement (Hurwitz, Lauricella, Hanson, Raden, & Wartella, 2015), and improved communication and child health outcomes (Stockwell et al., 2012; Wolff et al., 2016). While not from the pediatric rehabilitation literature specifically, the results of these studies demonstrate families' appreciation for the convenience of receiving educational information on their cell phones to support their children in diverse settings and circumstances. In a recent study examining parents' use of technologies for management of their child's health issues, 70% of participants were open to using technology to communicate with their healthcare

provider (Meyers et al., 2020). However, parents with low health literacy were reportedly less likely to use technology for health management than those with higher health literacy (Meyers et al., 2020), so it is important to offer a variety of communication methods and to respect the preferences of each family. Privacy, confidentiality and security are other concerns related to technology use that need to be considered when adopting technology for communication purposes (Wang, Blazer, & Hoenig, 2016).

Electronic communication methods, such as text messaging, email, mobile applications, or videoconferencing might allow for improved communication, information exchange and increased opportunities for resource sharing. Occupational therapists should ask families how they prefer to receive information and communicate when services first begin. Although therapists need to ensure they are following the privacy and confidentiality standards enacted by their regulatory college, and employer, there is an opportunity for colleges and employers to take an active role in supporting innovative and safe health technology practices to improve communication and overall engagement (Information Technology Association of Canada, 2018).

Lastly, families need to believe that the service meets the needs of their child to encourage engagement (King, Currie, & Peterson, 2014). Most families in this study reported that the service was inadequate in supporting their child, limiting the value they place on it. In most cases, service frequency and duration are prescribed by the funder. However, in some areas across Ontario, occupational therapists are implementing a tiered service delivery model. Tiered models allow occupational therapists to use clinical reasoning to deliver services based on the identified needs of the children, and their

response to interventions (Campbell, Kennedy, Pollock, & Missiuna, 2016). By providing supportive interventions for children proactively in a classroom-wide (tier one), or small-group setting (tier two), many children's needs may be met without requiring intensive, individualized service (tier three). This was demonstrated in a recent implementation and evaluation study of a tiered model called Partnering for Change (P4C), where multi-year waitlists for SBOT services were eliminated (Missiuna et al., 2015). Parents who interacted with the OT in this study reported that they were extremely satisfied with this service; however, researchers acknowledged that it was still difficult to connect with families and additional work was needed to reach parents (Missiuna et al., 2015). Instead of all children receiving the same type of service regardless of need, incorporating a tiered service delivery model, such as P4C, might allow for therapists to allocate more time to work with children who require more individualized or more intense intervention.

Limitations

Although efforts were made to recruit families with varying levels of engagement, family participants all identified as being highly engaged parents. Different perspectives and experiences may have been shared by families with varying levels of engagement. Additionally, all family participants identified as mothers. Fathers, and other family members, may have contributed distinct perspectives that are not represented in study findings. Finally, inclusion of the educator voice would have contributed to a richer understanding of the educator role in contributing to family engagement in SBOT services. Future research should focus on incorporating perspectives from more diverse families with varying levels of engagement and exploring the educators' role in family

engagement in SBOT services from the perspectives of educators. Additionally, further research is required to explore the transferability of our findings to other contexts.

Conclusion

This study aimed to explore how families and therapists engage in children's SBOT services, the factors that influence their engagement, as well as strategies to improve engagement in SBOT services. Family engagement was depicted metaphorically as a group dance with essential elements being the dancers, the choreography, and the music. The dancers represented a team approach to family engagement rather than only focusing on the actions of the family. The choreography not only represented how families and therapists engaged, but also highlighted some of the factors that influenced how they engaged, such as abilities, resources, trust and communication. Finally, the music represented contextually related factors that influenced family engagement, such as service and school factors, and the emotional connection with the dance overall. Strategies to improve family engagement from the perspectives of the participants were described throughout the metaphor and expanded upon in the discussion.

The participants in this study reported many challenges related to family engagement in SBOT services. Improvements related to family engagement in SBOT services will require significant changes to practice. Funding agencies need to be flexible in how services are supported and how occupational therapists are paid for their time. Innovative ways of incorporating technology would enhance opportunities for connection and communication. The adoption of service delivery models that endorse a needs-based approach to service, rather than a 'one-size-fits-all' approach is necessary to increase the

value families place on this service. Overall, transformation in service provision is essential to improve family-therapist connections and communication as well as increase the overall value of these services for children and their families.

Key messages

- Family engagement is defined by the actions of the entire team, rather than just those of the family.
- Family engagement depends on stakeholders' overall abilities and resources. Stakeholder roles should be negotiated based on families' individualized needs and preferences.
- There are substantial service factors that hinder family engagement. Major shifts in service are required to increase the value families place on school-based occupational therapy services.

Acknowledgements

The authors are grateful to The Canadian Occupational Therapy Foundation for funding this study, and for support from Dr. Wenonah Campbell's John and Margaret Lillie Chair in Childhood Disability Research appointment. The authors would also like to extend appreciation to the family members who took part in the development of the research study, and to the participants for their insights and time.

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Chapter 5. Discussion & Conclusion

In the applied health discipline of occupational therapy, family-centered service is an essential part of practice (Jaffe, Humphry, & Case-Smith, 2010). Working in partnership with families, occupational therapists facilitate capacity building to enable parents to participate in their child's occupational therapy services and make informed choices to best support their child (Jaffe et al., 2010). However, during my time working as a school-based occupational therapist, I found it challenging to connect with families for many reasons. Researchers have commonly reported that it is difficult for school-based occupational therapists to make meaningful connections with families in this setting (D'Arrigo, Copley, Poulsen, & Ziviani, 2019; Fingerhut et al., 2013). Unfortunately, my experience was that I did not find guidance in addressing these issues through peers, professional practice groups, or by reviewing the extant school-based literature. Recognizing that there likely was more to learn about this topic, and wanting to be able to support other school-based occupational therapists, families, and children by exploring this issue in greater depth, I chose to pursue a doctoral degree and make this a focus of my academic studies.

After scoping the available literature for studies related to family engagement in school-based occupational therapy services, it was apparent that there was limited published research pertaining to this specific phenomenon and context. However, some pediatric occupational therapy studies examined family engagement broadly, and the researchers demonstrated that school-based therapists had unique experiences of family engagement when compared to other pediatric occupational therapists working in other

settings (i.e. private practice) (D'Arrigo et al., 2019; Fingerhut et al., 2013). This literature validated my personal experiences and I surmised that the school-context impacted family engagement in a negative way. However, the research evidence exploring the reasons that family engagement is challenging in school settings was scant, deeming further qualitative research necessary.

My overall goal for this dissertation was to build on the breadth and depth of the currently available research by focusing solely on family engagement in the school context, and incorporating therapists' and families' voices to better understand family engagement from the perspectives of multiple stakeholders. Specifically, I aimed to achieve the following objectives:

1) **Describe and define family engagement** in the educational literature to improve school-based rehabilitation providers' understanding of this concept in this unique context, and to inform rehabilitation services that take place in schools rather than in typical rehabilitation contexts (Chapter 2).
2) **Explore and describe how families and therapists engage with each other** in school-based occupational therapy services (Chapter 4).
3) **Identify and describe the factors that influence family engagement** from the perspectives of therapists (Chapters 3 and 4) and families (Chapter 4).
4) **Develop stakeholder-informed solutions** to facilitate family engagement (Chapters 3 and 4).
5) **Develop practice and policy recommendations** to help mitigate challenges and facilitate family engagement (Chapters 2, 3, 4, and 5).

Overview of findings from each study

Chapter 2 -The concept of family engagement in education: What are the implications for school-based rehabilitation service providers?

The purpose of this study was to describe and define the concept of family engagement in the school context by scoping the educational literature, with a primary goal of informing school-based rehabilitation practice (objective #1). We employed scoping review methodology to locate the relevant literature (Arksey & O'Malley, 2005), and concept evaluation methodology (Morse, Mitcham, Hupcey, & Cerda Tasón, 1996) to evaluate five different conceptual components: *definition, characteristics, boundaries, preconditions* and *outcomes*.

We did not find a clear definition of family engagement in the included literature; however, we did identify some common characteristics. Our analysis of boundaries indicated family engagement and parent involvement are not synonymous but are closely linked. We also identified several preconditions for family engagement in education, including: an inviting and inclusive school culture; a broad understanding of engagement; positive educator-family relationships; and families' confidence, beliefs, and supportive life contexts. Outcomes associated with family engagement included academic achievement, high school completion, and child social-emotional functioning. After analyzing the concept based on these five evaluative components, we determined that family engagement is still emerging as a clear and distinct concept.

We proposed a broad definition of family engagement for educators and school-based rehabilitation providers to consider. We also discussed how applying a broader

definition of family engagement may facilitate trusting relationships and shared power with families. We argued all educators and school-based rehabilitation providers should consider how their own actions might better meet the individualized needs of families with whom they work. Finally, we highlighted the importance of providing culturally sensitive care, and opportunities for bidirectional communication.

Overall, we concluded that until further research is available that explores family engagement more specifically in school-based rehabilitation services, therapists working in the school context can reflect on the findings of this study to consider what actions can be taken to better support the individualized needs of families and children.

Chapter 3 - Making connections between school and home: Exploring therapists' perceptions of their relationships with families in Partnering for Change

The purpose of this study was to describe the factors that occupational therapists view as influencing the development of family-therapist relationships in Partnering for Change (objective #2), and to explore their ideas to improve relationship-building (objective #3). We followed a qualitative description design to explore the occupational therapists' experiences, and presented five main factors that reportedly impacted the development of family-therapist relationships: competing demands of both families and therapists; consistency and availability of therapists; awareness of occupational therapy services, and families' and therapists' readiness and commitment to engage with each other; therapists' relationships with schools and educators; and school and family-specific sociodemographic characteristics. The therapists in this study also were asked for suggestions for improving family-therapist relationships. All of the suggestions could be

categorized into two categories: increasing in-person interactions and increasing awareness of occupational therapy services.

When discussing the findings, we highlighted how recommending more in-person interactions might contribute to increased demands placed on families. Exploring other ways of communicating and connecting with families that do not require families to come to school, such as technology-based communication strategies might be other options to consider. Additionally, we suggested utilizing the existing relationships therapists had with schools and educators to make connections with families, especially when consistency and availability is not sufficient for relationship-building with families (i.e., in the case of larger schools). Finally, we discussed the novel skills required for the delivery of Partnering for Change, including the new role where therapists are typically the first to inform families about challenges a child may be experiencing. We recommended ongoing training and the establishment of a community of practice for occupational therapists adopting Partnering for Change as a model of practice to improve self-efficacy in taking on these new roles.

Overall, this study provided an improved understanding of the factors that influence family-therapist relationships in Partnering for Change, and explored ways that therapists can improve the relationships with families to support children's participation in both home and community settings.

Chapter 4 – The dance of family engagement in school-based occupational therapy: An interpretive description

The purpose of this study was to explore occupational therapists' and families' experiences of family engagement in school-based occupational therapy services (objectives #2 and #3), and to promote stakeholder-informed improvements to service delivery (objectives #4). We employed an interpretive description study design (Thorne, 2016). Ten family members and six occupational therapists participated in semi-structured one-to-one interviews. Data analysis was completed using inductive thematic analysis (Braun & Clarke, 2006).

The participants described family engagement in a way that can be represented metaphorically as a group dance. The essential elements for this dance were: the **dancers** (the family, the occupational therapist, and the school staff), the **choreography** (the actions of the family, therapist, and school staff in supporting the child), and the **music** (the context of the service). The group's performance depends on the **trust** and **communication** between the dancers, each dancer's individual **skills, resources, and expectations,** and the dancer's **emotional connection** with the dance itself. In addition, **contextual factors**, such as the school and service factors, were noted to have major influences on the overall performance. We utilized this metaphor as a method of organizing and illustrating the movement and interactions between the essential elements and the influencing factors.

The dance of family engagement demonstrates how stakeholders currently engage, and what influences their engagement. Importantly, the participants indicated that family

engagement involves more than just the family. Instead, it relied on the actions of multiple stakeholders. We argued that family engagement depends on how the team functions together, not only on the actions of the family. Additionally, the participants noted that the roles each stakeholder assumed (family, occupational therapist, school staff) depended on many factors including each stakeholder's individual skills, resources, and expectations, as well as the level of trust and communication between the stakeholders. We argued that establishing clearer expectations and negotiating the roles and responsibilities of each team member at the outset of service is necessary to enhance family engagement by aligning roles with individuals' capabilities. Lastly, school factors and service factors were noted to set the tone for family engagement, and elicit emotions, which impacted how the stakeholders engaged. We recommended that the service be transformed to support protected and funded time for families and therapists to connect, offer increased flexibility in communication methods (e.g., video conferencing, mobile application), and encourage therapists to use clinical reasoning skills to determine service frequency and duration. We argued that these changes would be expected to lead to a more positive experience for families by increasing the emotional connection with the therapist and service.

To summarize, in this study we explored and described how families, occupational therapists, and school staff engage in children's school-based occupational therapy services, identified factors that influence their engagement, and recommended stakeholder-informed strategies to improve engagement in school-based occupational therapy services.

A definition of family engagement

Engagement is a term that has been increasingly used in healthcare and rehabilitation in recent years; however, although research on engagement is emerging, there seems to be limited consensus regarding what it means to be engaged as a client (Bright, Kayes, Worrall, & McPherson, 2015). The similar, but distinct, concept of family engagement is also in the exploratory stages of concept development in pediatric healthcare and rehabilitation, with recent studies employing qualitative research to explore this concept in more detail (D'Arrigo et al., 2019; King, Currie, & Peterson, 2014; King et al., 2020; Phoenix et al., 2019a, 2019b). A major issue with research on family engagement is that there is no universal definition. A framework (King et al., 2014) and theory (Phoenix et al., 2019a, 2019b) have been proposed, but no concrete definition has been put forth. Without a clearly defined concept, it is difficult to expand knowledge and conduct research that is beyond exploratory in nature. My dissertation work contributes to the development of this concept, and presents a definition for consideration by researchers, service providers, and other important stakeholders. My work shares some similarities and differences with the existing literature on family engagement in pediatric mental health (King et al., 2014), occupational therapy (D'Arrigo et al., 2019), and rehabilitation (King et al., 2020, Phoenix et al., 2019a, 2019b).

Similar to existing research (D'Arrigo et al., 2019; King et al., 2014; King et al., 2020; Phoenix et al., 2019a, 2019b), I believe that family engagement in school-based rehabilitation services has affective, cognitive, and behavioural components (attitudes, abilities, and actions). Previous research acknowledges these three components, but

seems to endorse visible, behavioural components of the family as the most important indicator of engagement (D'Arrigo et al., 2019; King et al., 2014; King et al., 2020; Phoenix et al., 2019a, 2019b). For instance, D'Arrigo and colleagues (2019) describe various levels of family engagement from high parental 'engagement' (when it works well), to disengagement (when it doesn't work well). The indicators used to describe the levels of engagement are largely parents' behaviours, such as body language, non-compliance, and missing appointments. However, in my conceptualization of family engagement, the spotlight shifts from what the family does or does not do, to how the team members function to meet the needs of the family and the child. Family engagement includes the attitudes, abilities and actions of all team members, and only works well when all team members contribute to the process. For the purposes of school-based rehabilitation, team members include families, school-based therapists, educators, and other school staff. For other rehabilitation settings, team members may include other healthcare professionals, adults, or even peers that contribute to the child's overall progress and development.

In addition to engagement being seen as an affective, cognitive, and behavioural connection with the therapy process, King and colleagues (2020) describe engagement as a sense of working together. The caregivers who were interviewed in their study emphasized the importance of their relationship with the therapist. This relational component is present in all previous research on family engagement in healthcare and rehabilitation, and is considered to be essential (D'Arrigo et al., 2019; King et al., 2014; King et al., 2020; Phoenix et al., 2019a, 2019b). Similarly, I demonstrated the importance

of establishing a strong family-therapist relationship to support family engagement in my research, but I also emphasized the importance of the family-educator relationship and the therapist-educator relationship. Although my research is specific to school-based services, it might be important to consider how the relationships with other individuals in the child's circle of care influence family engagement as well.

Another important aspect of family engagement is the importance of individualization of family engagement to meet the needs of each family. This is implied in other conceptualizations of engagement in rehabilitation, but is not explicit (Bright et al., 2015; King et al., 2020; Phoenix et al., 2019a, 2019b). Individualization means that the roles and responsibilities of each team member may look different when working with different families. One family may require the therapist and school staff to take on more responsibility, and another family may want to take on more of a leadership role. Additionally, families should have agency and power to shape the experience of their engagement and overall service delivery, but this needs to be supported and facilitated by the organization and the service provider.

In my dissertation, I noted that the overall experience of family engagement is influenced by the trust families have with the therapist, and the use of effective and meaningful communication. The Phoenix Theory of Attendance, Participation, and Engagement also identifies communication as being one of the most important factors in determining whether a family would be engaged or not (Phoenix et al., 2019a, 2019b). Effective communication contributes to families' feelings of being supported and valued, and promotes the development of family engagement.

Based on the findings from each of the studies in this dissertation, I have developed a definition of family engagement that has important similarities to the current conceptualizations of engagement in pediatric rehabilitation, but some meaningful differences as well. Although other conceptualizations of family engagement focusing on clinic-based sessions may not transfer well to the school setting due to the emphasis on the behavioural component of engagement, my definition is meant to be broad enough to be considered in all areas of pediatric rehabilitation.

> *Family engagement is a multi-faceted 'umbrella' term used to describe team members' (families, service providers, educators, and other important team members) attitudes and actions towards a child's progress and development, and the dynamic process team members participate in to support a child's progress and development across multiple environments. Family engagement is characterized by strong relationships between team members, encompassing trust and effective communication. Power is shared amongst team members, but roles and responsibilities are shaped by the team members' abilities, and the individualized needs of the family, and may depend on their culture and past experiences.*

The purpose of creating this broad definition of family engagement is to fill a gap in current research, contribute to further concept development, and to provide a starting point for future research. This definition was reviewed with some of the participants in the interpretive description study; however, further validation is required.

The Model of Family Engagement in School-based Rehabilitation

Originating from the education literature, the Theoretical Model of Parental Involvement seeks to explain the reasons parents become involved in their children's education and the outcomes of their involvement (Hoover-Dempsey & Sandler, 1995; Hoover-Dempsey & Sandler, 1997). The Theoretical Model of Parental Involvement was

revised in 2005 with a focus on what influences parents' decisions to become involved in their child's schooling (Walker, Wilkins, Dallaire, Sandler & Hoover-Dempsey, 2005). The influences noted in this model include parents' motivational beliefs, parents' perceptions of invitations for involvement from others, and parents' perceived life context (Walker et al., 2005). The relevance of the revised Theoretical Model of Parental Involvement was evident throughout this dissertation; however, it is not comprehensive enough to explain all the factors that influence family engagement in school-based therapy services. This model only considers how parents' perceptions and beliefs influence their behaviour, and this dissertation demonstrates that there are many other factors, beyond family-specific factors, that influence families' behaviours. Furthermore, the collective findings in this dissertation demonstrate how family engagement is heavily influenced by the actions of the therapists and the school staff as well as many contextual factors.

With the purpose of informing school-based practice, and potentially family engagement in rehabilitation more broadly, I have developed the Model of Family Engagement in School-based Rehabilitation (see Figure 1) to illustrate the salient features of family engagement and to demonstrate the factors that influence it. The model depicted below was informed by the revised Theoretical Model of Parental Involvement (Walker et al., 2005), and the theory of Overlapping Spheres of Influence (Epstein, 1987), and incorporates the findings in this dissertation.

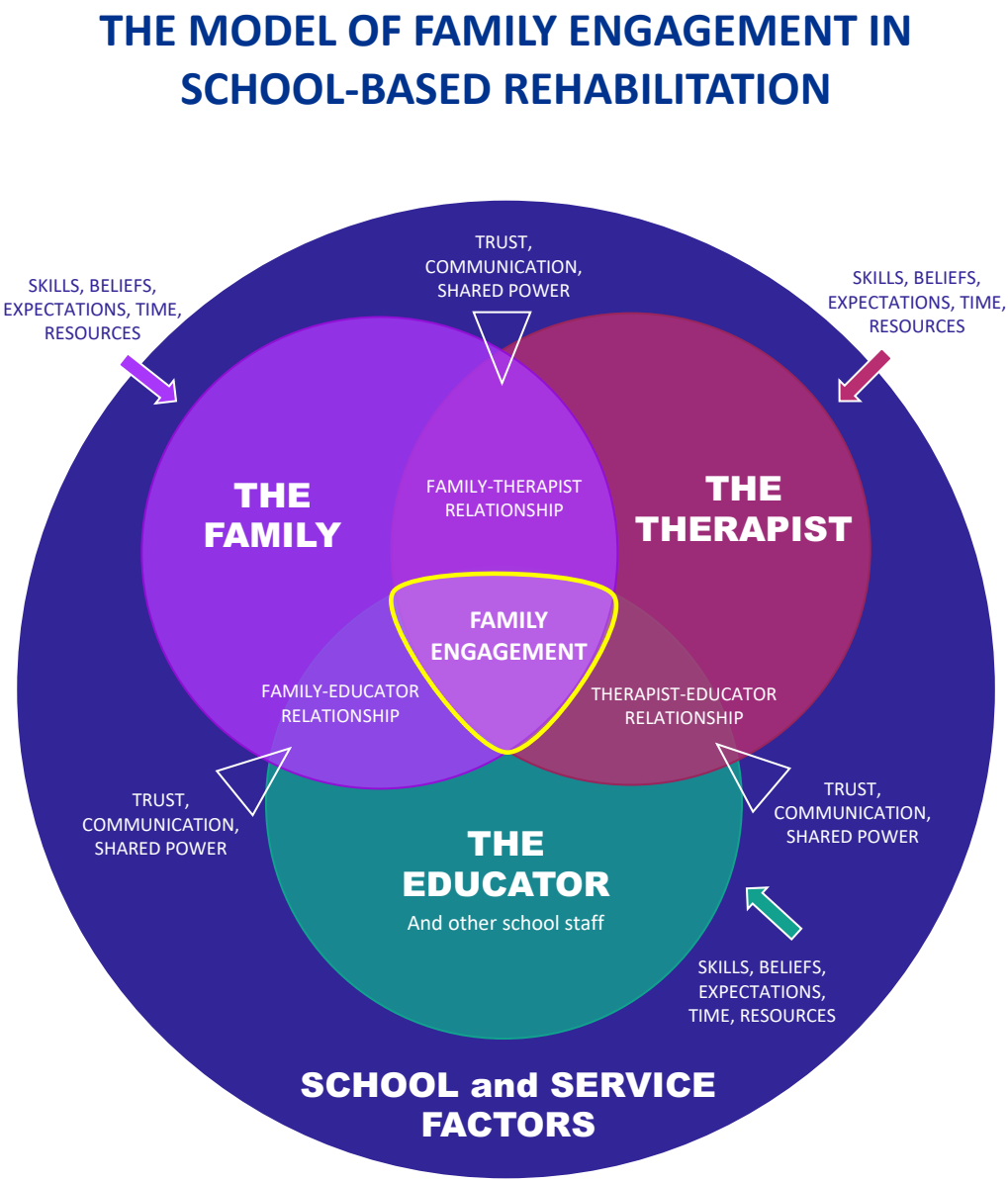

Figure 1. The Model of Family Engagement in School-based Rehabilitation

Epstein's (1987) theory of Overlapping Spheres of Influence demonstrates the importance of all 'spheres' that influence a child's overall development, namely the family and school spheres. In the Model of Family Engagement in School-Based Rehabilitation, I have added a sphere to represent the therapist. In this new model, the

family, the educator (and other school staff), and the therapist all influence family engagement, which ultimately influences the child's overall development. In the theory of Overlapping Spheres of Influence, Epstein (1987) describes how forces related to the family and school act on the spheres and lead to either further overlap, or separation of the spheres. The force acting on the spheres in the Model of Family Engagement in School-Based Rehabilitation include each stakeholder's skills (the capability to engage, and support the engagement of others), beliefs (beliefs about self, cultural beliefs, perspectives about roles and responsibilities, and values related to engagement), expectations (expectations of self and others), time (availability of time to put towards engagement efforts), and resources (availability of supports). Each force impacts how the stakeholder engages, and eventually, the degree of overlap between the three spheres. Some forces may pull a sphere further away from the other spheres, and other forces may push a sphere inwards. More overlap of the spheres signifies more family engagement, and more overall support for the child.

It should be noted that all five forces apply to each stakeholder, but factors within each force may look different for each stakeholder. For example, all stakeholders require the capability to engage, including having adequate cognitive abilities and communication skills. However, therapists also would need to have rapport building, and clinical reasoning skills to foster family engagement and support other stakeholders in their engagement. Educators might also need to have rapport building skills, but not clinical reasoning skills. Therefore, all stakeholders have skills that are required for

family engagement, but the skills that support family engagement vary between the stakeholders. This is true for the other forces acting on the spheres as well.

Additionally, there is overlap between the adjacent spheres representing the relationship between each pair of stakeholders. The more the adjacent spheres overlap, the stronger the relationship. The stronger the relationships are between the stakeholders, the larger the overlap between all three spheres. Therefore, family engagement not only relies on each stakeholder's skills, beliefs, expectations, time, and resources, but also on strong stakeholder relationships. The relationships are shaped by trust, communication and shared power amongst the stakeholders. Without ample trust, effective communication, and power sharing, the adjacent overlap between spheres will lessen, thus negatively impacting the relationship and family engagement overall.

Surrounding the spheres are the contextual factors that influence family engagement. Specifically, the service and school factors impact the forces that move the spheres, the ability to form strong relationships, and ultimately the amount of overlap between each of the spheres. For example, if the culture of the school is not welcoming to all families this may impact the trust the family has with the educator and other school staff, negatively impacting the family-educator relationship, and reducing the overlap of all three spheres.

Overall, the Model of Family Engagement in School-Based Rehabilitation illustrates the factors that influence family engagement in school-based rehabilitation services. However, these influencing factors also may be relevant in pediatric rehabilitation settings beyond school-based rehabilitation. The stakeholders included in

the Model of Family Engagement in School-Based Rehabilitation may be substituted for other stakeholders such as other healthcare professionals, or even peers, that contribute to the child's overall progress and development rather than, or in addition to, educators and other school staff. The model also is not limited to three spheres. All stakeholders that contribute to family engagement in rehabilitation services can be represented by their own sphere. Therefore, when aiming for family engagement in rehabilitation, therapists should consider the driving forces of each stakeholder, trust, communication, and power, and the contextual factors that may be impacting family engagement.

The Model of Family Engagement in School-Based Rehabilitation adds to the existing literature on family engagement in pediatric rehabilitation by shifting the focus from the family's actions, and mainly family-specific factors that limit the family's ability to engage in services, to how all stakeholders can influence, and contribute to, family engagement. This model has similarities with The Phoenix Theory of Attendance, Participation, and Engagement (Phoenix et al., 2019a, 2019b). This theory was created to depict the complex factors that prevent or promote parents' attendance, participation and engagement in clinic-based pediatric rehabilitation (Phoenix et al., 2019a, 2019b). Similar to the Model of Family Engagement in School-Based Rehabilitation, the authors of this theory suggest that parents' skills, values and beliefs impact their attendance, participation, and overall engagement. However, this study was focused on 'hard-to-reach' families and mainly focused on the familial factors that influenced family engagement. For instance, the researchers concluded that a parent's ability to attend, participate and engage depends on the family's composition (i.e., single-parent family, or

number of children with disabilities), child and family health complexity, as well as the number of organizations and service providers with which they currently work. Some professional and organizational factors (i.e., expectations that professionals and organizations hold of parents) are discussed briefly but the emphasis is primarily on the family factors.

The Model of Family Engagement in School-Based Rehabilitation insists the skills, beliefs, time, expectations and resources of the other stakeholders are equally as important to family engagement as the family's skills, beliefs, time, expectations and resources. Another important difference is the inclusion of shared power between the stakeholders in the Model of Family Engagement in School-Based Rehabilitation. This is an important factor as healthcare services continue to experience power imbalances that contribute to families feeling like they cannot or should not participate in decision making and other aspects of service (Joseph-Williams, Edwards, & Elwyn, 2014). To empower and engage families, it is important that therapists understand the value in families' contributions and do their best to reduce the power hierarchy. Therapists can share power by informing families about the many ways they can engage in services, and building families' beliefs in their ability to take part (Joseph-Williams, Edwards, & Elwyn, 2014).

Practice implications

The occupational therapists who participated in the interpretive description study seemed to be cognizant of when family engagement was not optimal (e.g., spheres pulling apart) and spoke about manifestations of guilt when discussing their experiences. Their experiences are a result of the combination of forces that are pulling the spheres apart,

creating barriers and challenges that are not easy to overcome. These study findings have important practice implications for school-based occupational therapists, schools, and service provider agencies. These practice implications are outlined below.

Implications for school-based occupational therapists

In this dissertation, Chapters 2 through 4 discuss the countless competing demands that families are experiencing in their lives. Therapists are urged to consider ways to reduce demands on families by offering options related to ways of connecting and communicating. One option may be to explore the possibilities of utilizing virtual healthcare with managers and service delivery teams. The Information Technology Association of Canada (2018) defines virtual healthcare as "any interaction between patients and their healthcare providers using information and communications technology" (p. 11). Studies have shown virtual healthcare methods may be beneficial in increasing parental engagement (Hurwitz, Lauricella, Hanson, Raden, & Wartella, 2015), and improving communication and child health outcomes (Stockwell et al., 2012; Wolff et al., 2016), making this a promising option. Providing flexible options for communication about services, and allowing families to choose which option works best for them may lead to equitable opportunities for increased family engagement.

Therapists are encouraged to learn about the families with whom they work; their cultures, their strengths, and what makes them unique. They are also encouraged to reflect on each family's individual needs and how they can be best supported. As a strategy to optimizing family engagement, it is recommended that school-based occupational therapists engage in conversations with families at the beginning of service to discuss

expectations and to allow families to choose ways of engaging that are meaningful for them (Phoenix, Smart, & King, 2019). Additionally, to provide more culturally safe and inclusive care, therapists should engage in training related to the provision of culturally sensitive care to increase awareness of the influence of culture on families' style of communication, beliefs about health, and attitudes towards healthcare (Donate-Bartfield & Lausten, 2002).

As a result of the findings in Chapter 2, it is recommended that therapists broaden the definition of family engagement beyond school-centric or therapist-centric views of what it means to be "engaged" and consider our newly proposed definition. This is important because many families are not able to engage in traditional ways (i.e., helping with homework, or completing therapist recommended home exercises) secondary to their work schedules, family demands, or difficulties communicating in English (Baker, Wise, Kelley, & Skiba, 2016; Carréon, Gustavo Perez, Drake, & Barton, 2005; Greenberg, 2012; McKenna & Millen, 2013). It is likely that families are already engaging meaningfully in ways that are manageable for them (Carréon et al., 2005, Posey-Maddox, 2017; Warren et al., 2009). Therapists are urged to take a strengths-based approach and acknowledge what each family is doing well, rather than focusing on what they are not doing.

Therapists are also encouraged to utilize relationships with educators to better connect with families. Therapists should try to make their presence known in the school community and become a part of the school culture. The school-based occupational therapy literature suggests that building strong relationships with educators and becoming

a part of the school community is critical to the success of services (e.g., Case-Smith & Holland, 2009; Rens & Joosten, 2014; Villeneuve, 2009). This may lead to increased awareness and acceptance of occupational therapy in the school setting and amongst families.

Finally, the Model of Family Engagement in School-Based Rehabilitation outlines the many forces that influence family engagement. Therapists are encouraged to use reflective practice and consider their own skills, beliefs, expectations and how they may be impacting family engagement. That said, school-based occupational therapists should show themselves compassion. They are working in a complex system that produces inherent barriers to family engagement. This work is not easy!

Implications for schools

To ensure successful partnerships and engagement from all stakeholders, it is imperative that schools establish a welcoming, culturally sensitive environment for *all* families, and welcome therapists as part of the school community. The culture of the school has major implications for family engagement (e.g. Barr & Saltmarsh, 2014; Carréon et al., 2005). Participation in practices that ensure families feel safe, respected and welcomed is essential for strong family-educator, and family-therapist relationships. Additionally, in Chapter 4, therapists reported that their efforts working with children and families are facilitated by a supportive school environment. It is recommended that schools attempt to increase the awareness of occupational therapy services by introducing the therapist to the school community.

Finally, schools can also broaden the perspective of what it means to be "engaged" beyond school-centric ways (i.e., volunteering). Having a broad understanding of family engagement allows families who engage in non-traditional ways to feel welcomed and respected in the school, and may promote further engagement in education (Goodall & Montgomery, 2014), and rehabilitation services that take place at the school.

Implications for service provider agencies

The service provider agencies that employ occupational therapists have influence over the flexibility of service, and ways therapists are permitted to work. To support therapists in expanding services to be more inclusive and flexible for families, service provider agencies should provide the infrastructure and training for the use of virtual healthcare options to increase accessibility and health equity. Additionally, therapists should be provided with training in the provision of culturally sensitive care, and have access to translators and translation services to ensure service accessibility.

Therapists and families acknowledged substantial barriers to bi-directional communication in Chapter 4. Other literature suggests that communication is one of the most important factors in determining whether a family engages in rehabilitation services (Phoenix et al., 2019a, 2019b). Current practices limit the ability for families to connect directly with therapists, which has implications for relationship building (e.g., poor communication practice and power differentials). Direct ways for families and therapists to communicate are recommended.

Chapter 4 highlights the importance of how a therapist is paid for their time. It is recommended that service provider agencies consider the limitations of the current

service delivery model and ways of improving system inefficiencies and inequities. Service provider agencies need to consider how different remuneration models might better serve the school community by allowing therapists to be paid for their efforts in connecting with families.

Overall, my dissertation work has highlighted the conflict between current school-based occupational therapy practices and family-centred values. Service provider agencies are encouraged to reflect on the current models of practice and the inherent barriers to family-centred care, and consider ways to make school-based services more family-oriented.

Policy implications

The therapists who experienced feelings of guilt should remember that they are working in a complex health care system and the onus to make change cannot be placed on them alone. Certainly, therapists have a role in adapting practice to facilitate family engagement, but greater change needs to happen at a systems level. In addition to the practice implications listed in the previous section, I outline important policy implications that need to be considered to support change for schools, regulatory colleges, service provider agencies, professional practice groups, and funders of service.

***Implications for school*s**

In the interpretive description study in Chapter 4, some participants outlined school-based policies that prohibited families from attending the school to meet with the occupational therapist. As noted in Chapter 3, given that therapists and families continue to place value on in-person services, it is important that this is at least an option. It is

recommended that schools establish policies that allow families to attend meetings with therapists at the school. Policies should protect students and school staff, but also consider ways to reduce barriers, and promote a welcoming environment.

Implications for regulatory colleges, service providers agencies, and professional practice groups

Before therapists can safely engage in virtual healthcare, regulatory colleges, and individual service provider agencies first need to establish privacy, security and confidentiality standards and policies (Wang, Blazer, & Hoenig, 2016). Professional practice groups should work with regulatory colleges to develop training related to these new standards and policies for service provider agencies and therapists wanting to adopt these practices. At the present time, these suggestions are already being put into action as a result of the COVID-19 pandemic. Regulatory colleges and professional practice groups are encouraged to continue promoting this new way of practicing once the pandemic subsides. Not only do these methods keep individuals safe from a virus, but they also provide a way to ensure more equitable and accessible care (Information Technology Association of Canada, 2018).

Finally, increased funding for school-based occupational therapy would support each therapist in having more time to engage in meaningful ways with families. It is the role of the professional practice groups to promote the profession of occupational therapy to policymakers, and to argue for dedicated funding towards service delivery models that value engagement with families.

Implications for funders

The amount of funding allocated to a service inevitably dictates how many children and families are expected to be served, and in what frequency and duration. Therefore, the type of service model that is feasible within the funding limits is ultimately dictated by the funder. Funders of services should consider tiered models that allow occupational therapists to use clinical reasoning to deliver services based on the identified needs of the children, and their response to interventions as a more equitable approach to service delivery (Campbell, Kennedy, Pollock, & Missiuna, 2016). A tiered model called Partnering for Change has been shown to eliminate multi-year waitlists for school-based occupational therapy services (Missiuna et al., 2015). Funding bodies are encouraged to consider tiered services as a more equitable, efficient, and potentially cost-effective way of service delivery.

Future research

In this dissertation, I have contributed to the conceptual and theoretical development of family engagement as a construct in pediatric rehabilitation research, with a particular focus on the school setting. Further research is required to contribute to ongoing concept development and refinement. As a next step, researchers should explore the perspectives of educators and other school staff to gain a more holistic understanding of their experiences with family engagement in school-based occupational therapy services. This may contribute to new insights and further refinement of the concept.

Additionally, researchers might engage stakeholders in a study to validate and further develop the proposed definition of family engagement and the Model of Family

Engagement in School-Based Rehabilitation. This may be done through a qualitative case study by exploring family engagement between triads of stakeholders working together (a family member, an occupational therapist, and an educator). This would provide an opportunity to study the application of the proposed definition and model, and also allow for exploration of the participants' reactions and interpretations of the definition and the model.

Further research also is required to explore the transferability of the definition and model to other contexts, such as clinic-based pediatric rehabilitation. This is important as there are aspects of the model that may not be specific to the school context, and may contribute to family engagement in other settings. A qualitative description study exploring clinic-based therapists' perspectives about the definition and model would be an appropriate study design.

Much of the research related to family engagement in pediatric rehabilitation has been exploratory in nature, and although this reflects the concept's current level of maturity and the need for concept development and clarification, it would be beneficial to be able to measure the impact of family engagement on child outcomes specifically. A team of researchers from around the world are currently engaged in a multi-year research project to develop a variety of measures of engagement from the perspectives of parents, children, service providers and observers (PRIME Research Team, 2015). It is unclear whether these measures will be applicable to school-based services or specific to in-person engagement; however, it is promising that there may be a way to measure the impact of family engagement in the near future. In the meantime, the development of

knowledge translation interventions to improve family engagement based on the Model of Family Engagement in School-Based Rehabilitation would be another way to validate relevant aspects of the model and contribute to concept refinement. Researchers should engage families, school-based therapists, educators and other important stakeholders on the usability of any interventions to enhance family engagement in school-based rehabilitation services, and assess their satisfaction with such interventions while measures are continuing to be developed.

Limitations

Due to the scant nature of the literature on the topic of family engagement in school-based occupational therapy, a limited number of studies were used to formulate the rationale for this dissertation. The state of the science also contributed to the research designs, which can all be categorized as exploratory. Generally, the quality of exploratory research is largely dependent on the researcher's skills, and can be influenced by the researcher's personal experiences and perspectives (Creswell, 2013). Although I maintained a reflexive journal, and engaged in many ways to limit bias and enhance the credibility of the studies, it is likely that I personally influenced the findings in some way. As such, further research is required to explore the validity of my findings, especially the Model of Family Engagement in School-Based Rehabilitation which was created individually. Finally, exclusion of the educator voice is a major limitation in this dissertation. Including educators in the interviews in the interpretive description study would have contributed to a richer understanding of the educator role in contributing to

family engagement in school-based occupational therapy services and further refinement of the Model of Family Engagement in School-Based Rehabilitation.

Conclusion

The experiences I had as a school-based occupational therapist challenged me personally and professionally. The lack of practice-specific guidance in overcoming challenges related to building relationships with families was the catalyst for commencing my doctoral journey. By setting out to explore this issue in great depth, I intended to create knowledge to support other school-based occupational therapists experiencing similar challenges, and successively increase the overall impact of school-based occupational therapy services for children and families.

Through the process of completing this dissertation I have explored the unique nature of the educational context in which school-based services take place (Chapter 2), contributed to the conceptual development of 'family engagement' (Chapters 2, 3, 5), provided an in-depth analysis of family engagement in school-based occupational therapy from the perspectives of multiple stakeholders (Chapter 4), created a Model of Family Engagement in School-based Rehabilitation (Chapter 5), and generated stakeholder-informed solutions for occupational therapy practice (Chapters 2, 3, 4, 5). My sincere hope is that this dissertation leads to increased guidance for occupational therapists who work in this unique practice setting, and to substantial improvements in families' experience of school-based occupational therapy services in Ontario. Future research is needed to continue to refine the concept of family engagement to be applicable to all

pediatric rehabilitation settings, and lead to the ability to measure the impact of family engagement on child outcomes.

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