Literature review of non-clinical competencies and skill mix required by interdisciplinary teams who support children with disabilities

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Contents

[Statement on Language 2](#_Toc203563192)

[Abbreviations 3](#_Toc203563193)

[Executive Summary 4](#_Toc203563194)

[Introduction 4](#_Toc203563195)

[Aim 4](#_Toc203563196)

[Methodology 5](#_Toc203563197)

[Findings 5](#_Toc203563198)

[Conclusion 6](#_Toc203563199)

[Introduction 7](#_Toc203563200)

[Aim 8](#_Toc203563201)

[Methodology 8](#_Toc203563202)

[Findings 9](#_Toc203563203)

[Skill Mix 9](#_Toc203563204)

[Non-clinical competencies 15](#_Toc203563205)

[National Team Development Programme 15](#_Toc203563206)

[NDA reviews of competencies for community-based disability services 18](#_Toc203563207)

[Competencies identified in the literature 19](#_Toc203563208)

[Limitations 25](#_Toc203563209)

[Conclusion 25](#_Toc203563210)

[References 27](#_Toc203563211)

# Statement on Language

In this report, we use the term “children with disabilities” which reflects person first language. This is in line with what is commonly used in disability services and reflects the language used in the UNCRPD (persons with disabilities). We recognise that the term ‘disabled persons/people’, which is considered to be identity first or social model language, is preferred by some people. Identity-first language acknowledges the fact that people with an impairment are disabled by barriers in the environment and society and so aligns with the social and human rights model of disability. We also acknowledge that some people do not identify with either term.

For further information on disability-related language and terminology, please refer to the NDA’s Advice Paper on Disability Language and Terminology.[[1]](#footnote-1)

# Abbreviations

| Abbreviation | Definition  |
| --- | --- |
| AAC | Augmentative and Alternative Communication  |
| AHA | Allied Health Assistant  |
| AOTA | American Occupational Therapist’s Association  |
| AOTI | Association of Occupational Therapists Ireland  |
| ASHA | American Speech-Language-Hearing Association  |
| BC | British Colombia |
| CAMHS | Child Adolescent Mental Health Service  |
| CAMHS-ID | Child Adolescent Mental Health Service in Intellectual Disability  |
| CDN | Children’s Disability Network |
| CDNT | Children’s Disability Network Teams |
| CHN | Community Healthcare Network |
| CHO | Community Healthcare Organisations |
| CMPt | Caseload Management Planning Tool |
| EIT | Early Intervention Team |
| FEDS | Feeding Eating Drinking Swallowing  |
| HSCP | Health and Social Care Professional |
| HSE | Health Service Executive |
| IDT | Interdisciplinary Team |
| MaST | The Management and Supervision Tool |
| MDT | Multi-Disciplinary Team |
| NDA | National Disability Authority |
| NDIS | National Disability Insurance Scheme |
| NHS | National Health Service |
| NRG | National Reference Group |
| NTDP | National Team Development Programme |
| ODE | Oregon Department of Education |
| OT | Occupational Therapist |
| PCC | Patient and Client Care  |
| PDS | Progressing Disability Services |
| PT | Physical Therapist |
| SAT | School Age Team |
| SLP | Speech Language Pathologist |
| WAT-T | Workload Assessment Tool for Therapists |
| UK | United Kingdom |
| USA | United States of America |

# Executive Summary

## Introduction

The Health Service Executive (HSE) reformed the structure of children’s disability services to a family centred bio-psychosocial model under the auspices of Progressing Disability Services (PDS) This programme was launched in 2011, with the aim of providing equity of access to services based on need, rather than geographical location or diagnosis. The programme also works in partnership with families to optimise outcomes for children and young people with disabilities within existing resources.(1)

 Central to the PDS was the development of the Children’s Disability Network Teams (CDNTs) service model that operate on an interdisciplinary basis, moving from the uni- or multi-disciplinary models traditionally employed by services.

Skill mix refers to “the mix of posts, grades, or occupations in an organisation.” (2) The skill mix is crucial to developing a service that is of maximum benefit to those in need of its services.

All disciplines in the CDNT service model work within an interdisciplinary team (IDT) team structure which consists of a number of professionals from different disciplines who work together and share information, decision-making and goal setting~~.~~ Working in IDTs requires the development of new competencies, comprising knowledge, skills, and attitudes, to ensure the optimal service is provided.

Previous work by the National Disability Authority and the Health Service Executive has advanced understanding the competency requirements within disability services.

Whether the skill mix and the competencies within the CDNT service model in Ireland is in line those in other jurisdictions is unknown. Therefore, this question will be explored within the literature review.

## Aim

This literature review aims to examine international literature to understand the optimal skill mix and key non-clinical competencies required for staff working in IDT based children’s disability service. This review will build on the work previously conducted by the NDA and the NTDP.[[2]](#footnote-2)

The research questions are:

1. How does the Irish CDNT skill mix align with the skill mix identified in other jurisdictions for staff working in community-based children’s disability services?
2. What are the key non-clinical competencies required to work in an interdisciplinary community-based setting?
3. To what extent do the competencies identified in the literature align with the existing framework in place for CDNTs?

## Methodology

A systematic search was performed across a number of electronic academic databases, and grey literature sources. Additionally, the professional bodies representing therapists in a number of countries were contacted to provide further information and insights.

Studies and reports were included if they met the following criteria: (a) focused on non-clinical competencies or skill mix (b) were available in English (c) based in a community setting; and (d) specific to Interprofessional team working.

The selected studies were screened for relevance based on the titles and abstracts. Full-text articles of potentially relevant studies were retrieved and further assessed for eligibility according to the inclusion and exclusion criteria.

After screening against eligibility criteria, data extraction was performed to capture key information, including the type of article, jurisdiction, and associated profession. A narrative synthesis approach was employed to summarize and integrate findings across the included studies.

## Findings

Each jurisdiction has developed its own structures for supporting children with complex disabilities, however the skills and roles required are similar and more than 20 roles were identified in children’s disability services in other jurisdictions. The professional roles most commonly available to children were occupational therapists, speech and language therapists and psychologists. Physiotherapists, dieticians and social workers were also widely used. Other roles identified included care coordinators, therapy assistants and behavioural therapists. The roles employed in the CDNT service model in Ireland were well aligned with those used internationally.

This paper examines competencies identified in the literature with those developed for the CDNT service model by the National Team Development Programme and previous work by the National Disability Authority (NDA) in 2018, on competency frameworks for community-based disability services.(3,4)

The literature indicates that the following non-clinical competencies are required for community-based teams that are interdisciplinary; interdisciplinary teamwork, family-centred approach, continuous learning, and whole systems thinking. When compared to findings in the international literature the NTDP competency framework was found to be a sound model that aligns well with non-clinical competencies in other community-based interdisciplinary teams. It could be enhanced by the addition of competencies relating to self-development, parity of esteem, whole systems thinking, and enhanced community living skills and supports.

## Conclusion

This review was limited by a lack of skill-mix literature that is specific to children’s disability services. There is also limited information on the mix of grades for optimal team performance. In relation to non-clinical competencies there was limited information on competencies specific to working in interdisciplinary teams.

This review found that the Irish CDNT service model is relatively well aligned with international practice around the skill mix employed and the non-clinical competencies used. For the CDNT service model competency framework to be implemented effectively it must be backed by policies, infrastructure and resources that are continually reviewed.

# Introduction

To adequately support children with complex disabilities the Health Service Executive (HSE) reformed the structure of children’s disability services to a family centred model under the auspices of the Transforming Lives programme and the Progressing Disability Services (PDS) programme.(5) The PDS programme proposed that children with complex disabilities should have equitable access to community-based teams and supports no matter their location or diagnosis.

The skill mix within a community-based disability services team such as a Children’s Disability Network Team (CDNTs) in Ireland is crucial to operating a service that is of maximum utility to those who use the service and ensuring equity of access. In this context skill mix refers to “the mix of posts, grades, or occupations in an organisation.” This includes the combination of activities or skills needed for each job within the organisation.”(2)

Complementing the skill mix are the competencies each team member requires to work effectively in their roles. Competencies are “the abilities of a person to integrate knowledge, skills, and attitudes in their performance of tasks in a given context. Competencies are durable, trainable and measurable through the expression of behaviours.” (6)

The competencies that staff require differ according to the type of team they are working in, and staff in CDNTs are now required to work in an interdisciplinary team (IDT) model. An IDT fundamentally changes the method of operating for Health and Social Care Professionals (HSCPs), many of whom were trained to work in a uni-discipline approach. An IDT consists of a number of professionals from different disciplines who work together and share information, decision-making and goal setting. They have common policies and procedures and frequent opportunities for communication. They work with the family and child, to meet their identified needs with a joint care and support plan.(7) Therefore, the change to working as part of an IDT means staff require different competencies from when they worked in either a uni-discipline or multi-disciplinary environment.

The National Disability Authority (NDA) previously examined the competencies and skill mix required for a community-based model of disability services in a series of reports. The findings showed that a substantially different way of working is required in community settings compared to institutional settings. The papers recommended the development of a specific competency framework for staff to help navigate this shift successfully. (3,4) However, these reports did not evidence which additional non-clinical competencies were needed for staff working in IDTs in community-based children’s teams.

Following the NDA reports the Health Service Executive (HSE) National Team Development Programme (NTDP) was tasked with defining the competencies required by CDNT staff to achieve their core deliverables. The core competencies were derived from the deliverables required in children’s disability services and were based on an expert group formulation rather than evidence from the literature.(1)

## Aim

This literature review aims to examine international literature to understand the optimal skill mix and key non-clinical competencies required for staff working in IDT based children’s disability services. This review will build on the work previously conducted by the NDA and the NTDP.[[3]](#footnote-3)

The research questions are:

1. How does the Irish CDNT skill mix align with the skill mix identified in other jurisdictions for staff working in community-based children’s disability services?
2. What are the key non-clinical competencies required to work in an interdisciplinary community-based settings?
3. To what extent do the competencies identified in the literature align with the existing framework in place for CDNTs?

# Methodology

A search was performed using the following electronic databases; EBSCO, ProQuest, Medline, SocIndex, and Google Scholar, and the following grey literature sources Cochrane Library, Social Care Institute for Excellence (SCIE) Trip Database, Global Index Medicus, National Institute for Health and Social Care Excellence (NICE), World Health Organisation, Agency for Healthcare Research and Quality, National Quality Forum, Lenus, Health Information and Quality Authority (HIQA), WorldCat and Scopus. The search strategy utilised a combination of relevant keywords, such as “interdisciplinary team\*,” multidisciplinary team\*”, “non-clinical competencies” “skill-mix” "paediatric/children’s disability services," and variations thereof. Boolean operators (e.g., AND, OR) were employed to refine the search and maximize the retrieval of pertinent literature.

The research team also contacted organisations of physiotherapists, occupational therapists, speech and language therapists, social workers and psychologists in Ireland, UK, USA, Canada, Australia, and New Zealand to seek out relevant materials. This resulted in some useful position papers.

The reference lists of key documents were searched for relevant material.

Studies and reports were included if they met the following criteria: (a) focused on non-clinical competencies or skill mix, (b) were available in English, (c) based in a community setting; and (d) specific to interdisciplinary team working.

Data extraction was performed to capture key information, including the type of article, jurisdiction, associated profession (for example Occupational Therapists, Speech and Language Therapists), competencies and skill mix.

A narrative synthesis approach was employed to summarize and integrate findings across the included studies. Themes, patterns, and commonalities were identified to highlight the current knowledge in the literature regarding competencies and skill mix for teams in children’s disability services and how they relate to the Irish CDNT service model.

# Findings

The literature indicates that although each country has its own unique framework for children’s disability services, the skill mix, roles and competencies employed within these systems remain largely consistent across borders.

## Skill Mix

### Children’s disability service roles

The review indicated that the structure of disability services is unique across jurisdictions. This section focuses on the types of professionals that make up children’s disability services regardless of the service model used: that is, it may include uni-disciplinary, multi-disciplinary or interdisciplinary configurations.

Despite the differences in the system structures, there are commonalities in the disciplines and roles utilised across countries. More than 20 different roles were described as being involved in therapeutic provision in children’s disability services across seven countries reviewed (including Ireland, Table 1).(8–26) There was no data available on the grade mix among these professions. The roles that are common to every jurisdiction are occupational therapist, psychologist, social workers and speech and language therapist. In the majority of jurisdictions dieticians and key workers, were also available to children’s disability services. Other commonly available skill sets include allied health assistants, art music and drama therapists, behaviour therapists, and chiropodists /podiatrists. It should be noted that while a particular discipline may be present in a jurisdiction it may not be present in every service location.

Table 1: Health and Social Care Professionals[[4]](#footnote-4) evidenced in children’s disability services in different jurisdictions

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **HSPC/Country** | **England**  | **Scotland** | **Australia** | **Canada** | **New Zealand** | **USA** | **Ireland** |
| Allied health assistant | **√** |  | **√** | **√** | **√** |  | **√** |
| Art music or drama therapist | **√** | **√** | **√** |  |  |  |  |
| Audiologists |  |  | **√** | **√** |  | **√** |  |
| Behaviour therapist |  |  | **√** | **√** |  |  | **√** |
| Chiropodists /Podiatrist | **√** | **√** | **√** |  |  |  |  |
| Developmental educatorAide  |  |  | **√** | **√** |  | **√** |  |
| Disability support workerSocial care workerFamily support worker |  |  | **√** |  |  |  | **√** |
| Dietician | **√** | **√** | **√** | **√** |  |  | **√** |
| Key workerCare coordinator[[5]](#footnote-5) | **√** |  | **√** | **√** | **√** |  | **√** |
| Occupational therapist | **√** | **√** | **√** | **√** | **√** | **√** | **√** |
| Optometrist |  |  | **√** |  |  |  |  |
| Orthotists | **√** | **√** | **√** |  |  |  |  |
| Physiotherapist/physical therapist | **√** | **√** | **√** | **√** | **√** | **√** | **√** |
| Play therapist/recreational therapist |  |  | **√** |  |  | **√** | **√** |
| Prosthetists |  | **√** |  |  |  |  |  |
| Psychologist | **√** | **√** | **√** | **√** | **√** | **√** | **√** |
| Social Workers | **√** | **√** | **√** | **√** | **√** | **√** | **√** |
| Speech and language therapist[[6]](#footnote-6) | **√** | **√** | **√** | **√** | **√** | **√** | **√** |

### Team composition in Ireland

In 2009 the HSE’s National Reference Group (NRG) on Multidisciplinary Disability Services for children aged 5-18 (27) identified the roles of occupational therapist, physiotherapist, social worker, psychologist, and speech and language therapist as being essential for an IDT in children’s disability services. These would allow for the provision of assessment, intervention, education, and training for children with disabilities and their families. In addition, they recommended that each team also include a clinical coordinator, a paediatrician, therapy assistants and administrative support. Each CDNT was to be provided with sessional input from a paediatrician, as well as a dietician and orthotist employed by the Local Health Office. (27)

Within the NRG report, it was specified that where there is only one post per team of a particular discipline, it should be filled at senior level, with additional staffing provided at grade level. (27)[[7]](#footnote-7)

According to the HSE’s 2024 CDNT Workforce report (28) CDNTs have allocated staffing that covers all the essential roles described by the NRG. However, the details of the available roles and grades were not available in the report and therefore it is unknown whether each essential role is available within each CDNT. (29)

The HSE divides CDNT roles into six categories HSCPs, Nursing, Patient and Client Care (PCC), Children’s Disability Network Manager (CDNM), Administration and General support. HSCP roles account for 73% of the filled WTEs in CDNTs and include dieticians, occupational therapists, physiotherapists, play therapists/specialists, psychologists, social care workers, social workers, and speech and language therapists. (30) PCC roles include Assistant Therapists family support workers, care assistants (disability services), health care assistants and early intervention specialists and Early Intervention Educator.

In the current CDNT service model structure, each team does not have their own sub-specialists or clinical specialists. Instead, the CDNT service model takes a tiered approach, where children with complex needs can be referred to receive enhanced support. For example, teams to support Feeding, Eating Drinking or Swallowing difficulties (FEDS) are available in some areas. (31) Children with complex needs in relation to FEDS will receive access to an expanded multidisciplinary team, including additional medical expertise at a regional level where available. The most complex cases will receive hospital-based services at a national level.

### Non-core or additional roles in children’s disability services

The literature highlights certain roles that are not classed as core roles in children’s disability services These are outlined below.

#### Nurses, Doctors and Other Medical Services

Although nursing posts, are routinely available to CDNTs in Ireland, they are less common internationally. While nurses weren’t specifically identified in the NRG report many were already embedded in children’s disability services and were transferred to CDNTs during reconfiguration. The UK provides nursing services specifically for children and young people with an intellectual disability in the community (32) and in the USA, students with disabilities have access to therapy and nursing services in schools.(8)

Although the NRG recommended a paediatrician be part of the CDNTs in Ireland, in practice these medical professionals are accessed through the wider Irish health service. Child Development Service teams in New Zealand can include a developmental paediatrician or paediatric registrar. (33)

In Ireland audiology and optometry services for children are accessed through primary care.(34) The HSE also offers podiatry services which can be accessed via referral.(35) Services provided by orthotists and prosthetics in Ireland are outsourced to organisations such as the National Rehabilitation Hospital.(36)

Psychiatrists were mentioned as being part of services for children with disabilities in Australia and Canada. However, this was typically in relation to the initial diagnosis of a condition such as autism (and thus eligibility for disability services) rather than on-going treatment or support. (37,38) In Ireland, psychiatry services are usually provided through referral to the Child Adolescent Mental Health Services (CAMHS) team, some of which include a specialist Intellectual Disability (ID) service. (39,40)

#### Social Care Workers, or Family Support Workers

Social care workers are frontline workers who support people with disabilities to live their day-to-day lives. For example, providing support with personal/health needs, and supporting social interaction and engagement in the community.(41)

Family Support Workers are closely aligned with social work, working directly with children and families providing practical and emotional support.(42) The work of Family Support Workers can include supporting parents/carers and siblings.(43)

The extent to which each post has a direct, international equivalent is unclear. For instance, in Australia under the National Disability Insurance Scheme (NDIS), disability support workers promote the empowerment and community participation of eligible individuals. (44) The disability support worker appears to encompass some of the elements of social care role, some of the family support role and some of the personal assistant making role comparisons difficult.

#### Developmental Educators or Aides

Developmental educators or aides are provided in children’s disability services in Australia, Canada and the United States. In Ireland the equivalent services are provided by the Department of Education through the provision of Special Needs Assistants and other in-school supports for children with disabilities and/or special educational needs.(45) However, the CDNT staff census does include a small number of educators. (28)

#### Play Therapists (Recreation, Art, Music, and Drama)

There are only a very small number of play therapists/specialists who are part of CDNTs in Ireland.(28) Play therapists also work with children with disabilities in Australia and the USA.(15) The benefits of play therapy include emotional release, enhanced communication, improved self-esteem, conflict resolution, and empowerment.(46) In the United States, the Individuals with Disabilities Education Act refers to recreation therapy. This includes assessment of leisure function, therapeutic recreation services, recreation programmes in schools and community agencies, and leisure education. (8) Children with disabilities in Australia can access art and music therapy using their NDIS community participation budget. (47) In England and Scotland, children with disabilities can access art, drama, or music therapists through the NHS.(12,13)

#### Allied Health Assistants

Several jurisdictions include allied health assistants (AHAs) who are professionals who are trained to support specific disciplines, including physiotherapy, occupational therapy, speech and language therapy, and psychology. The 2024 CDNT Workforce Report shows that AHAs are currently working in Ireland on a limited basis, but this number is planned to increase significantly.(28) Professional bodies support the introduction of AHAs in Ireland, provided that they are utilised appropriately, That is, they are allowed to operate within a specific scope of practice, while subject to supervision by a CORU-registered therapist.[[8]](#footnote-8) (48,49) Guidance has been issued to recommend appropriate strategies and actions for effective governance in this regard.(50)

#### Key workers

England and Ireland have a key worker or care coordinator role for children with disabilities.(25,26) In New Zealand, there are coordinators for young autistic children only. This includes children five years and under who are awaiting a diagnosis or who have been diagnosed within the last 12 months.(51) In Australia, NDIS recipients aged nine years and over can avail of the services of a local area coordinator. Their role is to help with the development and implementation of an NDIS plan, including practical information.(52) Across the Canadian provinces, different names are used for individuals that help families of children with disabilities coordinate their access to services. Terms include Family Service Worker (Manitoba), Family Support Worker (Ontario) or a Family Support for Children with Disabilities Worker (Alberta).(18)

Key workers have been used for a long time within other service models such as day services for adults with intellectual disabilities and mental health services. (53,54) However, it is a relatively new innovation in children’s disability services. The role has been introduced in England in response to research that found that health professionals lacked clarity about which team member was responsible for which element of care, especially care coordination.(55)

Research indicates that there are several interpretations of key working, with different implications in terms of cost-effectiveness and what the term covers. A key worker can refer to a named professional that clients can approach for advice, a lead professional who coordinates specialist services, or a dedicated care coordinator post. (56) The HSE has issued guidance stating that when allocating families to individual team members, consideration must be given to the level of support required. (57)

In the UK, the Lenehan review examined the care of disabled children with challenging behaviour and complex mental health needs. (58) The report recommended that children accessing children’s disability services should have a dedicated care coordinator. This has been taken on as a goal by the National Health Service.(25) Care coordinators are professionals that support persons living with multiple long-term conditions to receive the right care at the right time, by making connections across the health and social care sector. In the UK, care coordinators have a competency framework providing clear, consistent standards, establishing the values, behaviours, and ways of working.(59)

The National Institute of Clinical Excellence (NICE) in the UK also recognises that a dedicated key worker role would be preferred for children and young people under 25 with complex needs but noted that there is a lack of evidence to justify a specific post. As such, the guidelines recommend further research to establish effectiveness in terms of service delivery and cost. (60)

Within Ireland, the National Reference Group on Multidisciplinary Services for Children proposed a dedicated, key worker post to coordinate services across multiple agencies for children with exceptionally complex needs (12). In the current guidance to CDNTs it is recommended that the key worker role is embedded within the therapists’ duties and each team member is allocated to the keyworker role based on the best fit for the child’s needs.(57)

#### Behaviour therapists

The behaviour therapists role was present in Australia, Canada and to some extent in Ireland.(24) There is some variation in terminology across jurisdictions, with professionals known as behaviour therapists, behaviour specialists, behaviour interventionists, behaviour consultants, or behavioural support practitioners. These individuals work with other IDT members, to provide assessment and intervention for children with disabilities to address behaviours that challenge. Their overall goal is to reduce crisis situations and improve quality of life. (20,61)

# Non-clinical competencies

Staff working in community-based services for children with complex disabilities require a broad range of clinical and non-clinical competencies. Non-clinical competencies are described as: “the attitudes, habits and qualities that make…a well-rounded professional.”(62)

This review primarily focuses on non-clinical competencies for front line staff. Therefore, competencies specific to staff leaders or management such as risk management, workload management, or data collection are outside the scope of this literature review, as are competencies specific to clinical issues such as clinical governance, quality and safety. However, some of the competency frameworks examined include both clinical and non-clinical competencies and they are included for context.

The first part of this section describes the existing competency framework for the CDNTs. The second part examines previous work on competency frameworks for community-based disability services. The third part examines the international literature relating to competencies required for front line staff in community-based services.

## National Team Development Programme

The HSE’s National Team Development Programme (NTDP) was tasked with defining the competencies required by CDNT staff to achieve their core deliverables. The core competencies, published in 2019, were based on an expert group formulation focusing on the competencies required to deliver the 12 principles underpinning the CDNT service model.(1) Table 2 outlines the principles and the associated competency area.

**Table 2: Competencies Identified by the National Team Development Programme**

|  |  |
| --- | --- |
| **Principle** | **NTDP Competency** |
| **Bio-psychosocial Model** | The team understands the bio-psychosocial model, and regularly reviews and reflects on their understanding and interpretation of the model |
|  | The team functions in line with the bio-psychosocial model |
|  | The team engages in family centred practice |
|  | The team integrates and works in partnership with the wider community e.g. local services, community groups |
| **Equality of Access** | In depth knowledge and understanding of the NAP, including the purpose and operation of the ICSF, the National Policy on Prioritisation of Referrals for CDNTs and the National Policy on Discharge and Transfer for CDNTs |
|  | Members of the team who decide on referrals have the competencies in clinical reasoning required to make decisions on the most appropriate service to meet the child’s needs |
|  | Working with other services e.g. mental health, Primary Care, Tusla to provide clear and integrated pathways including joint working |
| **Accessibility** | The knowledge and understanding to provide accessible services and appropriate environment taking into account the varying needs of the children and families and maximising the outcomes of intervention |
|  | Provision of written information using Plain English as in HSE/NALA guidelines |
|  | Recognising the need for varying communication with families and other stakeholders support for children and families and how to access alternatives |
| **Family-Centred Practice** | Knowledge and competency in delivering family centred practice |
|  | Communication with families and other stakeholders skills, including listening, negotiating and resolving conflict |
|  | Interpersonal skills |
|  | The skills to deliver universal, targeted and direct supports |
|  | Understanding, knowledge and compliance with Informing Families guidelines |
|  | The skills to develop an effective IFSP |
|  | Setting goals with families |
| **Interdisciplinary Team** | Understanding of interdisciplinary team working, including shared decision making, reflection, joint goal setting and intervention, service planning and service development |
|  | Effective Communication with families and other stakeholders |
|  | Leadership for managers |
|  | Workload management |
|  | Flexibility and adaptability |
|  | Knowledge and understanding of others’ roles and responsibilities |
| **Accountability**  | Understanding of responsibilities |
|  | Understanding relevant legislation, duties and obligations |
|  | Understanding what data must be collected |
|  | Assessing and managing risk |
| **Inclusion** | Skills in empowering families in promoting their child’s independence |
|  | Knowledge of community resources and facilities |
|  | Building good relationships with the community |
|  | Empowering families to encourage their child’s participation in mainstream activities |
|  | Knowledge of services provided by DES, NCSE and DCYA |
| **Early Identification & Referral**  | Understanding and compliance with NAP |
|  | Provision of written and verbal information for those who have concerns about children to make appropriate referrals |
| **Clinical Governance and Evidence Based Practice** | Understanding and compliance with team’s clinical supervision policy |
|  | Understanding and compliance with quality systems in place |
|  | Understanding and compliance with Performance Management policy |
|  | Assessment of children who have the full range of complex needs and their families |
|  | Intervention with children who have the full range of complex needs and their families |
|  | Knowledge of specialist supports, when and how to access them |
|  | Enhancement of service delivery through audit of practice and competencies and team review |
| **Cultural Competence** | Knowledge, attitudes and skills to understand and appreciate cultural differences, including the varying cultural norms of child development and rearing practices |
| **Staff are valued and respected** | Understanding and compliance with dignity and respect in the workplace policies and codes of conduct. |
|  | Knowledge and understanding of other team members’ roles and responsibilities |
|  | Self-awareness and how behaviour and attitudes impact others |
|  | Management of change |
|  | Resilience |
|  | Flexibility |
|  | Workload management |
|  | Time management |
|  | Conflict management |
|  | Awareness of cultural differences |
|  | Awareness to promote a culture of health and wellbeing within the team |
| **Evaluation of Outcomes** | Goal setting with families |
|  | Developing and working with IFSPs |
|  | Recording and collecting data on outcomes for children and families |
|  | Making returns for local, CHO and national management |
|  | Enhancement and improvement of service through reflection on outcomes for children and families |

A strength of this framework is that it outlines team-based competencies rather than individual competencies. There are limitations of this framework. Firstly, the framework was based on expert group opinion which was not supported by a review of international literature. Secondly the framework amalgamates competencies with operational issues, for example, ‘making returns for local, CHO and national management’.

## NDA reviews of competencies for community-based disability services

The National Disability Authority (NDA) previously examined the competencies and skill mix required for a community-based model of disability services in a series of reports. (3,4) This was written in the context of transitioning people with disabilities from living in institutional settings to living in the community. Sixteen competency frameworks were selected for review (10 for frontline staff, three for professional qualification/registration, and three for the management/ organisational level). The top 20 of these, and the frequency with which they occurred, can be seen in Table 3.

**Table 3: Frequency of broad competency areas among 16 competency frameworks**[[9]](#footnote-9)

|  |  |  |
| --- | --- | --- |
| **No.** | **Broad competency area** | **Total****n=16** |
| 1 | Communication | 11 (69%) |
| 2 | Person-centred practice | 10 (63%) |
| 3 | Professionalism and ethics | 10 (63%) |
| 4 | Planning and organization | 10 (63%) |
| 5 | Evaluation, observation and assessment | 9 (56%) |
| 6 | Community inclusion and networking | 9 (56%) |
| 7 | Education, training and self-development | 9 (56%) |
| 8 | Community living skills and supports | 8 (50%) |
| 9 | Specific clinical support | 7 (44%) |
| 10 | Health and Wellness | 7 (44%) |
| 11 | Quality | 7 (44%) |
| 12 | Empowerment and advocacy | 7 (44%) |
| 13 | Safety | 6 (38%) |
| 14 | Resilience, positive attitude and openness to change | 6 (38%) |
| 15 | Cultural | 5 (31%) |
| 16 | Crisis prevention and intervention | 4 (25%) |
| 17 | Respect dignity and privacy | 3 (19%) |
| 18 | Innovation, creativity and problem solving | 3 (19%) |
| 19 | Staff management | 3 (19%) |
| 20 | Leadership | 3 (19%) |

The findings showed that a substantially different way of working is required to effectively support disabled people in community settings. The papers recommended the development of a specific competency framework for staff to help navigate this shift successfully.

## Competencies identified in the literature

This section reviews the international literature on competencies from community services generally such as older person services or primary care in community settings and specific to interdisciplinary team working. There were four competency groupings identified interdisciplinary teamwork, Family centred approach, continuous learning and whole systems thinking. Any overlap or divergence from the non-clinical NTDP framework competencies and the NDA identified competencies are discussed. The literature examined was not necessarily specific to children with disabilities.

### Interdisciplinary teamwork

The IDT competency incorporates the significant shifts required in the way professionals work. This competency incorporates a number of elements outlined in more detail below, including positive work culture, parity of esteem, problem solving and shared decision making, and communication. The NTDP identified inter-disciplinary teamworking as a key competency for staff within CDNTs. They noted that IDT working includes shared decision-making, reflection, joint goal setting and intervention, service planning and development. To deliver IDT working CDNT staff require interpersonal skills, effective communication skills, ability to manage their workload, flexibility and adaptability, coupled with a knowledge and understanding of each other’s roles and responsibilities. (1)

#### Positive work culture

Team members must understand and respect professional boundaries and understand the perspective of other professionals to resolve conflicting opinions quickly. Positive teamwork within IDTs is facilitated by all members having a shared understanding of professional boundaries and appropriate governance structures, working practices, protocols, and access to shared IT systems. (63)

At an organisational, level, practice norms and shared values can facilitate co-practice[[10]](#footnote-10) for children with disabilities in the community.(64) Shared values exist in a self-reinforcing loop, resulting from and creating increased levels of trust and reciprocity. Examples include empowering leadership and ensuring respect for personal contributions, while challenging power hierarchies. At the individual level, increased social capital between staff promotes and/or results in a shared understanding of roles and distribution of knowledge. This manifests in the nature of communication between individual practitioners and creates safe spaces for open and honest dialogue, which is relevant, timely, responsive, and clear.

The NDA’s previous work refers to the competency of professionalism and ethics for disability staff which is relevant to this competency.(4) Broadly speaking, the NTDP recognises that staff must be valued and respected within their working environment. This includes promoting a culture of health and wellbeing within the team which will contribute to a positive work culture.(1)

#### Parity of esteem

Parity of esteem is an additional competency within teamwork that is new to IDTs. Parity of esteem is an understanding that all professions' skills, knowledge and understanding must have equal status. Members of IDTs previously worked in a hierarchal structure, with registered professionals traditionally residing at the top.

For IDTs to be family-centred and most effective, all team members must receive parity of esteem. While this process requires a significant mind shift from all team members, one way to promote parity of esteem is to ensure all members of the workforce have a role in the co-production of policies, strategies and budgets. (65). Another way is to request that all team members are referred to similarly (either using first names or all using titles), rotating the chairperson role between team members, and encouraging a culture of co-decision making and mutual accountability.(66)

Although parity of esteem is not specifically mentioned in the NTDP, it may be encompassed within the principle of ensuring that staff are valued and respected. This includes knowledge and understanding of each other’s roles and responsibilities.(1) Neither is it specifically mentioned in the NDA review of competency frameworks but it may be linked to the competency of resilience, positive attitude, and openness to change.

#### Problem-solving and shared decision making

The Problem-solving and shared decision-making competency involves the ability to analyse situations, generate solutions and collaborate effectively with others to make informed consensus driven decisions. Improved capacity for collaborative problem-solving and shared decision making can be fostered through regular team meetings to build trust and relationships as well as support for aligning care coordination and activities.(55,67) Among the key characteristics of an effective IDT is the development of trust through valuing individual contributions and fostering consensus.(68) This is particularly important for problems for which there are no evidence-based solutions or guidelines. (69)

Within the NTDP, shared decision making is referenced as part of interdisciplinary team working. (1) The competency of conflict resolution and negotiation is also referenced and would play a role in problem solving. In the NDA review of competency frameworks innovation, creativity and problem solving was identified in some frameworks. (4)

#### Communication

In an IDT setting there is more interpersonal communication with staff from other disciplines and the communications with families and children may be conducted in conjunction with another staff member and through a more formal family-centred approach.

Effective communication is the ability to listen actively and emphatically, engage with family members and children to convey information in a jargon-free and non-judgemental manner. This also extends to cultural humility when working with interdisciplinary colleagues and can include avoiding discipline-specific terminology. (6) Moreover, it is the ability to communicate the care plan and relevant information clearly, while adapting to the most appropriate style of communication.(69)

Interpersonal skills and relationship building has a substantial role within IDTs, as team members are expected to create and expand working relationships with staff across traditional organisational boundaries. This process is important as team members need to shift their mindsets and reshape their skills in order to develop working relationships with multiple parts of the system.(65)

The competency of communication emerged clearly within existing frameworks. Within the NTDP, it is associated with the principles of accessibility in terms of varying communication for families and other stakeholders. In terms of family-centred practice, communication is included as a key competency, along with listening, negotiating, and resolving conflict. (1) Communication was also the most frequently occurring competency for disability services staff in the NDA review of competency frameworks.(4)

### Family-centred approach

One of the key components of the Irish approach to children’s disability services as delivered through CDNTs is a family-centred approach. This is reflected in one of the major over-arching principles of the NTDP and its associated competencies whereby staff in children’s disability services are required to have knowledge and understanding of family-centred practice.(1)

The NDA competency frameworks review focused on adult disability services which have a corresponding emphasis on person-centred practice. (4) This is also reflected within the competency of respect, dignity and privacy within the NDA review.

Family-centred practice has been described as follows:

“Specifically, professionals must know how families function, understand various challenges families encounter, know-how families can cope with a child’s disability, understand various challenges professionals encounter in communication and interaction with the family system, know how to approach the family system in a holistic way (always dealing with their unique backgrounds, networks, and traditions), understand how to co-construct a plan of intervention with the family (empowerment, resilience), and understand the concept of partnership.” (70)

Family-centred practice involves engaging with a wider ecosystem of actors involved in the care of children such as family, siblings, grandparents, and significant others, and adapting a communication style that is most suitable for the family and that is clear and delivers information that is both general in terms of wellbeing and specialist in terms of the child’s specific disability or difficulty.(70) Staff will need to develop skills to support family well-being and be comfortable with the co-production of care plans and treatment.(55)

Staff must be supported to embrace the different values among families. This requires the socio-cultural competency which is

“the ability to learn about, understand and accept the importance of variations in cultural norms, and to apply this knowledge to overcome cultural barriers in providing people-centred care.”(71)

While the literature recognised cultural competence as a subcategory of family-centred practice, it can also be considered a stand-alone competency. The NTDP extends this to awareness of cultural differences in terms of valuing or respecting staff.(1)

### Continuous learning

The pace of health and social care reform is accelerating due to research and technology advancements and changing population expectations. It follows that staff in IDT’s will need to be much more prepared for life-long learning.(72) Continuous learningis the

“ability to demonstrate reflective practice, based on the best available evidence and to assess and continually improve the services delivered as an individual provider and as a member of an interprofessional team.”(69)

Continuous learning can be supported by developing a growth mindset which promotes motivation and productivity, provided that it is carefully and consistently developed and nurtured within a team. This can be promoted within IDTs by supporting staff to step out of their comfort zone, for example by giving them a placement within another part of the health and social care system. There are certain techniques that can support the development of a growth mindset within the team if they are embraced consistently over time.(65) For instance, IDT members must have access to professional development opportunities, including training.(68)

Existing frameworks for disability services staff reviewed by the NDA identified two competency areas linked with continuous learning. The first one refers to resilience, positive attitude and openness to change. The second refers to education, training, and self-development.(4)

The NTDP competencies make minimal reference to continuous learning or development at an individual or team level. (1)

Self-awareness and self-reflection are important to support continuous learning and require “reflective learning about belief systems and practices regarding inclusive activities and participation.”(73) Specifically, it requires team members to reflect on their preconceptions, reflect on their skills and knowledge to ensure tasks are carried out professionally, and reflect on their actions and emotional reactions.(70) The NTDP competency framework mentions reflection to improve outcomes.(1)

### Whole systems thinking

Developing knowledge and understanding of the wider health system is central to thriving within an IDT and delivering a family-centred approach. For staff to be able to provide families with general information on how to support their child and guide them through the system, they must be aware of and understand the roles of other staff, teams and organisations within the health and social care system. This is necessary for a successful transition to family-centred and interdisciplinary models of practice. Team members benefit by knowing the role of their fellow team members, and their respective boundaries. (74) Within the NTDP competency framework the principle of equality of access requires staff to have the competency of in-depth knowledge of other services and various policy related to referral within the system and to work in partnership with local services and community groups in the wider community.

Due to the level of knowledge sharing required within an IDT, team members must have the digital skills to communicate in a time-efficient and effective manner. Within IDTs, information sharing is more critical than in traditional disciplinary teams as sharing and communication across the team are critical to the success of the team. In addition to digital skills among team members, appropriate ICT infrastructure, connected databases, and information-sharing agreements must be available to be effective.(72)

The competency of whole systems thinking is not explicitly included within the NTDP. However, the evaluation of outcomes, data collection and service improvement are competencies for CDNT staff and would be enhanced by whole system thinking.(1) Planning and organising was a key competency identified in the NDA review of competency frameworks and this would also link with this competency of whole system thinking.

# Limitations

The duties and responsibilities of many of the disciplines employed in different services and jurisdictions, as identified in the skill mix section of this report, may differ, meaning some of the functions of a discipline may be subsumed into an aligned discipline. This unclear division of duties and responsibilities makes an understanding of the roles required more nuanced than is available in the literature. Further research is necessary to understand which skills are shared between disciplines. In addition, information on the grades of staff in various roles was not available and an appropriate mix of grades in addition to skills is important for optimal functioning.

In relation to the non-clinical competencies part of this paper there is a limitation in that the majority of the competency literature was from community services such as older person services or primary care and was not specific to children with disabilities. However, the main competencies identified should be transferrable to children’s disability services although more research and publication of implementation experiences is required. Likewise, there is a shortage of literature on IDTs as many teams continue to take a siloed or discipline-specific approach to care, making it more difficult to find information on the skills and competencies used within IDTs. This review found no universal definition of an interdisciplinary team and therefore what one group of researchers call an IDT may not align with another group of researchers.

# Conclusion

This report reviews the skill-mix present in community-based children’s disability services across a number of jurisdictions. It summarises the roles present in children’s disability services within six international jurisdictions plus Ireland. There is a wide range of roles employed in children’s disability services and while there are differences between countries Ireland is relatively well aligned with the most common roles in place internationally.

The report also provides an overview of the non-clinical competencies required to work in community-based children’s disability services through an IDT and family centred practice model. The non-clinical competencies identified within the literature are well aligned with those established by the NTDP with some minor differences. The competency of continuous learning is not explicitly stated in the NTDP competency framework but was a key competency in the literature. Parts of the competency of whole system thinking are included in the NTDP but as the CDNTs continue to move towards digital collection of data further training will be required. Parity of esteem, one of the competencies related to working in an ITD was not explicitly mentioned in the NTDP but was highlighted in the literature as an important competency area.

The literature didn’t identify competencies associated with accessibility of services or supporting inclusion. These were identified in the NTDP framework and inclusion was identified in the NDA review of competency frameworks. Building on previous work by the NDA, the review shows that while some competencies do not translate directly from one setting to another, they are firmly rooted in the same values. For instance, ensuring parity of esteem and whole systems thinking requires resilience, a positive attitude and openness to change. Other competencies such as empowerment and advocacy, community inclusion and networking may be more relevant for adult disability services. However, as the CDNT Service Model is a community-based model, it could be argued that the young people that they serve would benefit from staff having enhanced competencies explicitly related to community living skills and supports.

The division between clinical and non-clinical competencies is somewhat arbitrary as is the division between the competencies required for staff versus management. Therefore, competency frameworks must be developed in a holistic manner that encompass all competencies required. The NTDP competency frameworks has developed a sound model that is team based. It could be enhanced by the addition of competencies relating to self-development, parity of esteem, whole systems thinking, and enhanced community living skills and supports. For the framework to be implemented effectively it must be backed by policies, infrastructure and resources that are continually reviewed.

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1. <https://nda.ie/publications/nda-advice-paper-on-disability-language-and-terminology> [↑](#footnote-ref-1)
2. This refers to the programme for Children’s Disability Network managers and Children’s Disability Network Teams to support the move to the PDS model of service. For more information see: <https://www.hse.ie/eng/services/list/4/disability/progressing-disability/> [↑](#footnote-ref-2)
3. This refers to the programme for Children’s Disability Network managers and Children’s Disability Network Teams to support the move to the PDS model of service. For more information see: <https://www.hse.ie/eng/services/list/4/disability/progressing-disability/> [↑](#footnote-ref-3)
4. Please note that not all HSPC roles identified by the HSE are relevant to children’s disability services <https://careerhub.hse.ie/pathways_hscp/> [↑](#footnote-ref-4)
5. Different terminology is used for this role in various jurisdictions. See below for details. [↑](#footnote-ref-5)
6. Alternatively known as a speech language pathologist. <https://www.ucc.ie/en/speech/faq/s-t/> [↑](#footnote-ref-6)
7. Otherwise known as graduate/entry level. For more information on competencies for specific grades, see reports of the Project Therapy Office. <https://www.ucd.ie/phpss/t4media/Therapy%20Project%20Office_Physiotherapy%20Competencies.pdf> [↑](#footnote-ref-7)
8. CORU is Ireland's multi-profession health regulator responsible for regulating health and social care professionals. It includes the Health and Social Care Professionals Council, and the Registration Boards established under the Health and Social Care Professionals Act 2005. [↑](#footnote-ref-8)
9. Only competency areas where at least three of the 16 competency frameworks had a competency in that area are included in Table 1. Five competency areas which were included in only one competency framework were excluded. These were human rights based approach; low arousal philosophy and practices; family and carer interventions; knowing and understanding relevant legislation; and context. [↑](#footnote-ref-9)
10. This is another term for collaborative practice which occurs between different health, social and educational professionals working with children with disabilities. [↑](#footnote-ref-10)