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Facts To Go...

Volume 7, Issue 4 November 2011

A Service Delivery Model for Pediatric Rehabilitation

Purpose of Summary

The **purpose** of this *Facts to Go* is to **present <u>in brief</u>** the **"Life Needs Model"** (LNM) of pediatric service delivery. This model was developed by Dr. Gillian King, in collaboration with clinical directors, service providers, and centre administrators at Thames Valley Children's Centre (TVCC) (**to learn <u>in detail</u>** about how the model was developed and how it has been integrated into research and practice at TVCC, **please see** King, Tucker, Baldwin, Lowry, LaPorta, & Martens, 2002; King, Tucker, Baldwin, & LaPorta, 2006).

Origins of the Model

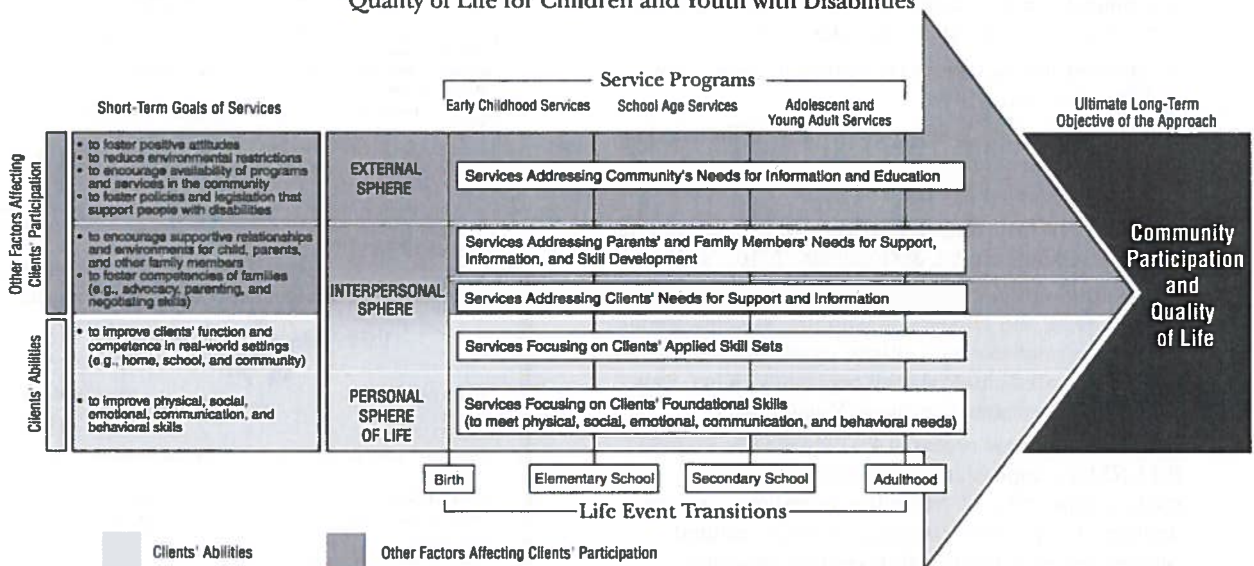
The LNM was **based on knowledge gained from collaborations** with families, clinicians, and community members, **and the research literature** in the fields of pediatric rehabilitation and developmental disability.

Basic Description of the Model

The model as **portrayed in the figure below** presents the types of services required to meet the needs of children and youth with disabilities, their families, and their communities. **Three spheres of life** of a person (Lindström & Köhler, 1991) are displayed on the left side of the arrow: the personal (individual characteristics/ abilities), interpersonal (relationships), and external (the greater community). These spheres are associated with services addressing **five major kinds of needs**. The top of the arrow identifies service programs organized by a child's age. The bottom of the arrow identifies transition points where needs change as a child develops and the environment changes. Short-term goals of services are provided on the far left. As the spectrum of services are delivered over time, the ultimate objectives at any stage of development are **community participation** and **quality of life** (QOL).

A Life Needs Model of Service Delivery

Services to Support Community Participation and
Quality of Life for Children and Youth with Disabilities



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Why a Life Needs Model?

Few health care service delivery models exist in the literature (King et al., 2006). The LNM was originally developed to extend the organizational vision of TVCC: **"Our clients at their best"**, and to guide long-range planning. The goal was to make available to all stakeholders a model that would provide a rationale for the range and scope of services required to best meet the major types of needs of children, their families, and their communities.

Five Major Needs

The **most useful aspect of the LNM** is perhaps the specification of five major types of needs that have been consistently identified by recipients of health services (King et al., 2002):

- the need to build **client foundational skills** (e.g., communication, mobility);
- the need to build **client applied skill sets** (e.g., maintaining friendships, engaging in community activities);
- the need for **client support and information** (e.g., coaching to foster self-determination, youth groups);
- the need for **support, information, and skill development for clients' family members** (e.g., family support groups, parent coaching); and
- the need for **information and education within communities** (e.g., advocacy efforts, community collaborations).

The LNM illustrates that a comprehensive, continuum of services with an emphasis on transitions is essential to **address the multiple, ongoing, and interconnected needs** of individuals, families, and communities.

Conceptual Influences

The LNM was originally **informed by trends** that have contributed to a broadened view in the field of pediatric rehabilitation in the last two decades, such as:

- **family-centred service** (Rosenbaum, King, Law, King, & Evans, 1998);
- the importance of **person-environment interaction** to health, functioning, and development (Bronfenbrenner & Ceci, 1994);
- a **focus on fostering strengths** as well as addressing needs (Chung, Burke, & Goodman, 2010); and
- the **notion of participation and QOL**, or overall well-being and satisfaction with life, as being among families' and society's ultimate goals for *all* children, and also what children want personally (King, Law, King, Rosenbaum, Kertoy, & Young, 2003).

Most recently, **new research knowledge** has extended the LNM by emphasizing the importance of relationships and goal orientation to pediatric service delivery (King, 2009). Building on family-centred service concepts, **relationship-centred practice** (Servais, Baldwin, & Tucker, 2009), **relationship-based organizations**, and **the pursuit of client-selected goals**, that are supported by practitioner and organizational goals are now accentuated as central to the provision of optimal services (King, 2009). A **relational goal-oriented model of service delivery** has been proposed by Dr. King that complements the LNM by elaborating on "how" services can best be provided (for further detail, see King, 2009).

The **extended vision**, then, of TVCC for clients has become "one of true participation and integration, where environmental supports, positive community attitudes, and strengths of individuals converge to **support people in pursuing their own goals and reaching their potential"** (p.65, King et al., 2002).

Utility of the Model

The LNM has thus far been useful at TVCC as a framework for developing an **organizational culture**, designing and refining **clinical services and programs**, advancing **therapist expertise**, allocating **resources**, guiding **research**, and enhancing **community partnerships** (King et al., 2006).

Since its inception, the LNM has been adopted by numerous other health care organizations in Canada, and in countries such as Norway and Australia. **Information from other organizations** and **future research** will be helpful in further understanding the utility and relevance of the LNM, and how it may be further extended.

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