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International Journal of Speech-Language Pathology
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713736271

Clinical reporting by occupational therapists and speech pathologists: Therapists' intentions and parental satisfaction

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Online Publication Date: 01 March 2004

To cite this Article Donaldson, N., McDermott, A., Hollands, K., Copley, J. and Davidson, B.(2004)'Clinical reporting by occupational therapists and speech pathologists: Therapists' intentions and parental satisfaction',International Journal of Speech-Language Pathology,6:1,23 — 38

To link to this Article: DOI: 10.1080/14417040410001669471
URL: http://dx.doi.org/10.1080/14417040410001669471

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Advances in Speech–Language Pathology, Vol. 6, No. 1, March 2004, pp. 23 – 38

Taylor & Francis healthsciences

Clinical reporting by occupational therapists and speech pathologists: Therapists' intentions and parental satisfaction

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Abstract

This study employed a qualitative research design to explore therapists' and parents' perspectives of paediatric occupational therapy and speech pathology assessment reports. Aims of the study were to explore the intentions of therapists when writing reports, to expand upon existing literature on parental satisfaction and preferences with respect to paediatric clinical reports, to highlight documentation practices that would serve to maximize parental use of allied health reports, and to develop specific guidelines on how reports can be written to ensure they are useful and beneficial to therapists and parents. Participants were 15 parents of children who had been assessed at 1 of 2 university clinics and subsequently received a written report, and 11 therapists employed at the same university clinics. Questionnaires were used to seek information from therapists concerning the purpose of assessment reports and essential aspects to include when writing reports for parents. In-depth interviews were used to seek information about how understandable and beneficial clinical reports were to parents. The data were subjected to thematic analysis. From comments of therapists' intentions and parents' stated needs, and in accordance with literature reviewed, guidelines were identified for the production of parent-oriented reports. Conclusions drawn from this study can be specifically applied to services producing paediatric occupational therapy or speech pathology assessment reports, but are widely relevant to paediatric allied health services.

Keywords: *Clinical reporting, allied health intervention, parent satisfaction.*

Introduction

Written reports are considered an essential component of therapeutic intervention, used by therapists for communicative, administrative, and legal purposes (Fedden, Green, & Hill, 1999; Simpson, 1998). However, many therapists would consider report writing the least preferred aspect of their work. Clinical report writing is time-consuming and often seemingly without immediate benefit. Most therapists suspect that their reports are seen merely as a record of events, without further usefulness.

The purpose of clinical reports has changed over time. Traditionally, reports have been regarded as a diagnostic record, providing the reader with profession-specific assessment data (Mayman, 1959). In contemporary health care, reports are viewed as both a form of accountability and a means of promoting the family's inclusion in the therapeutic alliance (Rafoth & Richmond, 1983). Such evidence of accountability and quality of service is particularly pertinent when adopting a family-centred approach to intervention (Flynn & Parsons, 1994; Rutherford & Edgar, 1979; Simpson, 1998; Viscardis, 1998).

Reports provide an accountable record of assessment, serving as a baseline to monitor changes in the status of a client over time (Cranwell & Miller, 1987; Gunter, 1985; Hegde & Davis, 1992; Meitus, 1983; Ownby, 1997; Pannbacker, 1975). Furthermore, they partially satisfy our "... professional responsibility to our clients to demonstrate that our interventions are efficient and effective" (Wallen & Doyle, 1996, p. 172). Clinical reports are seen as the predominant method of communication among professionals, the client and family, and other service providers (Flynn & Parsons, 1994; Isett & Roszkowski, 1979; Pannbacker, 1975; Thompson, 1997).

As the primary means of information exchange, clinical reports can facilitate communication between therapists and family members (Rafoth & Richmond, 1983). The current trend towards family-centred service in health care reflects recognition of

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ISSN 1441-7049 print/ISSN 1742-9528 online © The Speech Pathology Association of Australia Ltd
Published by Taylor & Francis Ltd
DOI: 10.1080/14417040410001669471

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parents' and service providers' partnership in paediatric intervention (Brown, Humphry, & Taylor, 1997; Rosenbaum, King, Law, King, & Evans, 1998; Viscardis, 1998; Wallen & Doyle, 1996). The advent of greater parental involvement in therapy, as well as the increasing practice of distributing clinical reports to a number of different consumers, including parents, school teachers, and medical and allied health professionals, necessitates writing clinical reports in a way that is of practical benefit to the various readers. Few therapists would disagree with this premise. However, in practice, this aim can become overshadowed by the need to generate an "output" (i.e., producing a document, regardless of its usefulness). Recent research findings indicate that reports are not providing parents with the information they desire (Flynn & Parsons, 1994; King, Law, King, & Rosenbaum, 1998). It appears that reports have become procedural outputs at the expense of clinical outcomes.

Cranwell and Miller (1987) identified reports as a source of parents' indirect exclusion from the therapeutic process, with parents' limited comprehension of reports inhibiting their understanding of the services provided. Weddig (1984) stressed the importance of parent-oriented documentation, stating "... if reports are not readable by parents, then parents are, in fact, being denied information related to their child" (p. 477).

Therapists have questioned the usefulness of reports as both a clinical tool and means of communication with others. Clinical reports are often organized according to test results and contain an abundance of specialist terminology or jargon (Flynn & Parsons, 1994; Meitus, 1983; Wiener, 1985). Although this is the type of report most commonly prepared by occupational therapists and speech pathologists, therapists have raised doubts about its usefulness (Flynn & Parsons, 1994). It is recognized that reports containing specialist jargon are often not read by consumers, nor viewed as helpful in clinical decision making (Zins & Barnett, 1982) and as a result are seen as a considerable waste of the therapist's time and effort (Dalston, 1983; Flynn & Parsons, 1994; Knepflar, 1976; Rafoth & Richmond, 1983). Despite an expression of dissatisfaction amongst therapists, there has not been significant change in the format used for clinical reports over time (Flynn & Parsons, 1994).

Specific limitations of clinical reports include the use of jargon terms, unclear or imprecise language, omission of basic information, poor organization and grammar, reported findings not supported by observations, impersonal statements, and too much focus on the clients' impairments (Cranwell & Miller, 1987; Flynn & Parsons, 1994; Garfield, Heine, & Leventhal, 1954; Mayman, 1959; Moore, 1969; Ownby, 1990; Pannbacker, 1975; Rafoth & Richmond, 1983; Tallent & Reiss, 1959a,b; Wiener, 1985). These limitations have been found to contribute to ambiguity, misinterpretation, and reduced understanding of reports, thus limiting their educational value and preventing effective communication between the therapist and the reader (Flynn & Parsons, 1994; Rucker, 1967; Tallent & Reiss, 1959a,b; Weddig, 1984).

Report writing practices need to be addressed in order to ensure therapists' time on this task is well spent, resulting in effective communication between the therapist and the readers, and greater engagement of family members in the therapeutic process. To achieve this, it has been suggested that reports need to facilitate parents' awareness of the nature of their child's difficulties, address the purpose of tests used and the implications of assessment findings, and provide a rationale for recommendations made (Cleminshaw et al., 1996; Masterson, Swirbul, & Noble, 1990). Furthermore, authors advocate that reports include non-ambiguous language and non-technical terms, a clear interpretation of test scores and concrete recommendations (Cleminshaw et al., 1996; Cranwell & Miller, 1987; Flynn, & Parsons, 1994; Grime, 1990; Knepflar, 1976; Weiner, 1985). The report also needs to be organized according to specific areas of functioning (Bagnato, 1980; Cranwell, & Miller, 1987; Flynn, & Parsons, 1994; Grime, 1990; Isset, & Roszkowski, 1979; Tidwell & Wetter, 1978; Weddig, 1984; Wiener, 1985). It is believed that implementation of these suggestions would lead to increased parental understanding of and satisfaction with reports. This, in turn, may lead to greater satisfaction for therapists, as the benefits of the report-writing task, including more effective inclusion of family members in the therapeutic process, become apparent.

The majority of studies to date have utilized closed-response parent and teacher questionnaires based on pre-determined categories drawn from the literature or rating scales to examine reports (Flynn & Parsons, 1994; Garfield et al., 1954; Grime, 1990; Isett & Roszkowski, 1979; Ownby, 1990; Rafoth & Richmond, 1983; Tidwell & Wetter, 1978; Weddig, 1984; Wiener, 1985). Few authors of studies have investigated the preferred features of reports from the parents' perspectives. Nor have the intentions of therapists when writing reports been explored. These intentions are of fundamental importance when investigating clinical report writing, as the purpose attributed to reports can influence the nature and direction of the service provided. Consequently, this project considered occupational therapists' and speech pathologists' perspectives regarding documentation, as well as their intended outcomes of reports.

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The purpose of the current research project was, therefore, to explore therapists' perspectives on clinical report writing and to expand upon the existing literature on parental satisfaction and preferences with respect to paediatric occupational therapy and speech pathology reports. These reports were seen to be representative of the way in which information is provided by allied health professionals to families. The study therefore aimed to attain an awareness of documentation practices that would serve to increase therapists' satisfaction with report writing and maximize parental use of allied health reports. Furthermore, the study aimed to develop specific guidelines on how these reports can be written to ensure they are beneficial to parents.

Method

The study was conducted at two university clinics, an occupational therapy clinic and a speech pathology clinic. These clinics offered assessment and intervention services for children with a range of diagnoses and difficulties, including delayed or disordered speech and language development, developmental coordination disorder, autistic spectrum disorder, attention deficit disorder and dyspraxia. Both clinics provided education to undergraduate and postgraduate occupational therapy and speech pathology students. In addition, these clinics interacted with the educational programmes and other professional services with which children may have been involved. The effectiveness of reports as a source of information and communication was therefore a salient issue in these settings.

The style of reports written in the clinics varied. Report proformas were available in both clinics to guide documentation of client assessments. In the occupational therapy clinic this was in the form of a comprehensive example report based on a fictitious client, aimed towards parents. In the speech pathology clinic the proformas used were not necessarily aimed towards parents and varied widely across individual therapists. For example, some therapists used a standard list of headings, while others referred to more complete examples.

Research design

Qualitative methods are applicable when the researcher seeks to identify and describe people's experiences, and further explore their opinions and interpretations of these experiences (Boman & Jevne, 2000; Segal, 1998; Taylor & Bogdan, 1998; Verkerk, 1999). In this study, the views and perceptions of therapists and parents regarding paediatric assessment reports were of central interest. The use of open-ended questionnaires and in-depth interviews in the study allowed for exploration of participants' own perspectives and the issues they considered important (Denzin & Lincoln, 1998). The use of document review allowed for comparison of therapists' and parents' perceptions with evidence from the reports provided to parents. This also facilitated, to some degree, triangulation of the data (Gliner, 1994; Rubin, 2000).

Participants

Three groups were invited to participate in the study: occupational therapists, speech pathologists, and parents. The occupational therapists and speech pathologists were employed as clinical educators at the university clinics. Their role was to supervise undergraduate occupational therapy or speech pathology students in the assessment and intervention of children attending the clinics. The children were assessed by either the clinical educators (hereafter, therapists) or by the undergraduate students, who were closely supervised by the therapists throughout the assessment and report-writing process. Assessment reports were either written by the therapists or written by the undergraduate students, under the supervision of the therapists. In either case, the therapists took ultimate responsibility for assessment reports produced in the clinics. Where the report had been written by undergraduate students, it was proof-read by the supervising therapist and amendments made, where necessary. Every draft of an assessment report was checked by the supervising therapist to ensure it met a professional standard, as deemed by the therapist. The final draft was co-signed by the therapist before it was given to the parents. Each of the parents in the study had had their child assessed at either the occupational therapy or speech pathology university clinic and had subsequently received a written assessment report.

Researchers sought the opinions of occupational therapists, speech pathologists and parents in order to ascertain the relative success of assessment reports in fulfilling therapists' stated aims and meeting parents' needs. A further rationale for consulting all 3 groups was to enhance credibility of the data through source triangulation (Gliner, 1994; Rubin, 2000). This contributed to the rigour of the investigation, and confidence in conclusions drawn from the research (Krefting, 1991).

Therapist participants. The occupational therapy clinic manager provided names of 6 clinical educators who had conducted assessments within the clinic in the past 6 months. Each therapist was contacted by telephone and agreed to complete a questionnaire. A questionnaire and explanatory letter were

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sent and 3 completed questionnaires were returned. The speech pathology clinic manager provided names of 10 clinical educators who were each provided with a questionnaire and explanatory letter inviting them to participate in the study. Eight completed questionnaires were returned. Although inclusion criteria did not stipulate a therapeutic association between therapists and families involved in the research, all 3 occupational therapists and 2 of the 8 speech pathologists had either produced or supervised at least one assessment and subsequent report reviewed for the study. Therapists reported prior clinical experience ranging from 5 – 17 years within the field of paediatric occupational therapy or speech pathology, and practice in the composition of various styles of reports.

Parent participants. Purposive sampling (Francis-Connolly, 1998) was used to recruit parent participants. As the researchers intended to explore parents' abilities to interpret and use the assessment reports provided by the clinic, selection criteria for the study excluded families who had previously received speech pathology or occupational therapy assessment or intervention from another service. It was thought that prior experience with occupational therapy or speech pathology services might have influenced parents' perceptions and understanding of the initial assessment report (Cranwell & Miller, 1987).

Occupational therapy and speech pathology clinic databases were accessed to obtain a list of possible parent participants. A list of 27 occupational therapy families was obtained, 14 of these families were randomly selected and invited to participate in the study. Ten families from the occupational therapy clinic agreed to participate. For 9 families, only 1 parent was interviewed. Both parents were interviewed for the remaining family. A list of 15 families was generated from the speech pathology clinic database. The speech pathology clinic manager contacted each family to gain their permission to be contacted by the researcher. Eight families agreed to be contacted and 5 subsequently agreed to participate. For 4 families, only 1 parent was interviewed. Both parents were interviewed for the remaining family.

Ages of participants' children ranged from 4 – 11 years of age, an age range representative of the clinics' clients. Children attended both government and non-government schools and parents were from a range of educational and professional backgrounds.

Procedure

Data collection for this study included three phases: (1) therapist questionnaires; (2) in-depth interviews with parents and (3) analysis of the readability and style of reports.

Therapist questionnaires. A questionnaire for speech pathologists was designed and implemented first. This questionnaire sought information about speech pathologists' reasons for writing assessment reports, the intended audience of the report, their perceived usefulness of the report to parents, important factors to consider when writing reports for parents and the influence of student involvement in the report writing process. After receiving the completed questionnaire, 1 of the 8 speech pathologist participants was contacted by telephone in order to seek clarification of some responses. After reviewing the speech pathologists' questionnaire and discussing the questionnaire format, the occupational therapists' questionnaire was developed. In addition to seeking similar information to that sought in the speech pathologists' questionnaire, the occupational therapists' questionnaire also sought information about participants' work history and their perceptions of the importance of report-writing, the time involved in writing the report, the length of the report, the use of profession specific terminology and their views on the assessment procedure.

Five of the 11 therapists in the study (i.e. 3 occupational therapists and 2 speech pathologists) had written reports for the families involved in the study. In addition to the questionnaire, these 5 therapists were provided with a copy of the relevant reports and asked to make additional comments pertaining to the reports.

Parent interviews. Semi-structured, in-depth interviews were conducted with parents to gain an understanding of the perception and utility of paediatric occupational therapy and speech pathology assessment reports (Taylor & Bogdan, 1998). In-depth interviews allow participants to talk freely and openly, and to use their own concepts and terms to express their opinions (Denzin & Lincoln, 1998; Stainback & Stainback, 1988). Prior to the interview, parents were sent a topic guide to encourage personal reflection and assist them in preparation for the interview (Patton, 1990; Taylor & Bogdan, 1998). The topic guide addressed themes such as the assessment experience, parents' expectations of the assessment and the report, parents' knowledge of the role of occupational therapists/speech pathologists, the content and benefit of the report, and their recommendations to therapists regarding report writing.

Interview questions were designed to ascertain the ease with which parents were able to understand reports as well as the perceived benefits. In relation to parents'comprehension of the report, parents

were asked to comment on: the intelligibility of words, phrases and sentences used throughout the report; the organization of the report (format); the detail of information presented in the report; grammar; and the overall tone of the report (positive or negative). Using a technique similar to that described by Cranwell and Miller (1987), participants were asked to read through the assessment report with the interviewer and identify words, phrases, or concepts they considered to be unfamiliar or difficult to understand. With regard to the perceived benefit of the report, parents were asked to comment on the following areas; what the report told them about their child, how they used the information, and the helpfulness and implementation of recommendations. In considering parents' familiarity with occupational therapy or speech pathology services, interviews also explored families' experiences during the assessment session. The researchers felt that the parents' perspectives regarding this initial contact might contribute to their perception of reports, and the usefulness of these documents.

Interviews were conducted at parents' homes, with the exception of one interview, which occurred at the parent's workplace. Interviews were audio tape-recorded and ranged from 50 min to 2 h duration. The interviewer had had no prior involvement in the child's attendance at the University clinic.

The researchers reviewed interview transcripts in order to determine parents' general impressions, common attitudes and inconsistent or contrasting opinions. Member checking (Francis-Connolly, 1998; Marshall & Rossman, 1995) occurred 5 months after the initial parent interviews. In the occupational therapy clinic, 2 of the parents attended a group meeting for this purpose. In speech pathology, individual member checking occurred via a written summary which 4 parents returned by mail. Salient themes from interviews were raised with the parents, providing them with the opportunity to further explore and express their opinions regarding pertinent research issues (Kitzinger, 1995; Verkerk, 1999).

Document review. The researchers reviewed the readability and style of the assessment reports sent to the 15 families to gain further information regarding the association between therapists' intended and actual documentation practices. The Flesch Readability Scale was used to calculate the degree of reading difficulty of the reports (Reed, Connelly, Gorham, & Coxhead, 1993). This scale provides a method of measuring the reading ease of the report by calculating the number of words and syllables used and the average length of sentences (Flesch, 1974). Each report was examined for the style in which it had been written and similarities and differences in report style were noted.

Data analysis

Questionnaire data. The occupational therapy and speech pathology responses initially were analysed separately by two of the researchers. Written responses on each questionnaire (for both groups) were read through and responses to individual questions were collated across questionnaires. Occupational therapy and speech pathology responses to similar questions were then compiled together. All responses from the questionnaire data were later compared to the parent interview data and common or contrasting perspectives identified.

Interview data. The parent interview data was transcribed verbatim and analysed using inductive analysis to enable a greater understanding of the data when coding and categorizing the information (Mason, 1996; Patton, 1990). The occupational therapy data and speech pathology interview data were coded separately by 2 of the researchers. For each set of data, a process of cross-checking was undertaken to ensure consistency of data interpretation (Patton, 1990). This involved independent coding of some of the data by a third researcher and subsequent discussion among researchers to determine the final set of codes for each set of data.

Document review. The occupational therapy and speech pathology assessment reports were reviewed separately by two of the researchers. The headings used in each report were noted and the content of each report was summarized to allow for comparison of style across all reports in the study. Application of the Flesch Readability Scale involved tallying the number of syllables in a 100-word sample of each report. Average sentence lengths were then calculated in order to apply a reading ease formula to each sample (Flesch, 1974).

Results

Document review

In order to provide a context for understanding the themes emerging from the questionnaire and interview data, the findings from the review of the reports will first be described. The reports in this study varied in style. Examination revealed variations among all the reports with regard to format, length, terminology, and content. Several basic similarities were evident between the way in

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which occupational therapy and speech pathology reports were written. Reports from both clinics included the demographic details of the child, tests used and the results obtained in either percentile or standard scores. All reports were structured according to similar sections, for example, background information, assessment results, summary, and recommendations. However, writing styles between reports from the two clinics differed in the following ways. The occupational therapy reports routinely included a summary of the child's medical and developmental history and the reason for referral whereas the speech pathology reports inconsistently included this information. The speech pathology reports provided information on test scores and a rating of the child's performance, for example ''average performance''. However, test scores in the occupational therapy reports were often accompanied by a functional interpretation of the results, for example the implications of test scores on the child's performance in the classroom. Differences were also apparent in the recommendations sections of the reports. The speech pathology reports gave a recommendation regarding the need for therapy. The occupational therapy reports recommended a range of further services appropriate to the child's needs, for example, therapy, a school visit, a home program. In addition, all occupational therapy reports included several practical strategies applicable to school and home tasks. Some parents from the occupational therapy clinic also received worksheets with recommendations for development of specific skills (e.g., handwriting).

Using the Flesch Readability Formula (Pace, 1961), both occupational therapy and speech pathology reports were calculated to have a reading level of university education or greater. This is the second highest level of readability, indicating that the general population would have found the reports difficult to read.

Emergent themes from the questionnaire and interview data

The themes reported were generated from the therapist questionnaire and parent interview data. Themes were initially identified separately for the occupational therapy and speech pathology data, however, as significant similarities were evident, the themes from each set of data were combined. Information obtained from each data set is reported as relevant under each theme, namely: therapists' intentions and parents' expectations of the report, the relationship between the assessment session and the report, readability of the report, and the use of the report.

Therapists' intentions and parents' expectations of the report

All therapists in the study identified parents as an intended audience for reports. However, while all occupational therapists considered parents to be the report's principal audience, not all speech pathologists identified them as the primary target group. Four speech pathologists identified student clinicians and other clinical educators as their primary target audience. Other target groups identified by both occupational therapists and speech pathologists included school teachers, other occupational therapists or speech pathologists, doctors, guidance officers and other allied health professionals.

Parents' expectations of the report content varied according to their previous experiences with health professionals outside of the respective university clinic. Prior exposure to professional reports about their child led parents to have expectations about the report they were to receive. Two predominant expectations from parents, regardless of past experiences, were that the report would: (1) provide information about their child's performance; and (2) include specific recommendations or practical strategies they could implement at home to assist their child.

Provision of information. Overall, parents expected the report to provide information about the tests used and the results obtained from these tests, an identification of the child's areas of difficulty, information on severity level, and the implications of the assessment findings. Although parents' endorsed the description of the assessment procedure provided in the report, their primary concern lay with the outcome of the testing. One parent noted that she had wanted to know ''. . . where [her child was] going, how he did in each area . . . whether he passed or didn't pass or was he in the average basically''. Review of reports revealed that parents' expectations of information about their child's abilities was largely met. Most reports detailed the tests used and the child's performance on these. However, several parents had anticipated the inclusion of information regarding their child's ongoing and/or future needs. These families sought greater awareness of the impact that the child's difficulties may have on current and future ability. Some parents had been aware of their child's difficulties prior to the assessment but had been seeking further exploration of the reasons for their child's difficulties or contributing factors. Two therapists had also considered this an important feature of reports. However, functional implications of the child's difficulties on daily tasks and future learning had not been consistently included in the reports.

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Some therapists commented on the importance of reporting on both the child's strengths and weaknesses, noting that the inclusion of such comments provides a holistic picture of the child. One speech pathologist demonstrated an awareness of the sensitive nature of assessment reports, noting that "they (reports) have the potential to upset parents". Another speech pathologist commented on the importance of "showing sensitivity to parents' feelings and concerns about their child".

Provision of recommendations. Parents from the occupational therapy clinic and parents from the speech pathology clinic expressed contrasting views regarding the provision of recommendations. Most parents who received an occupational therapy report found that the recommendations provided in the report had suited their needs. The parents' expectation, that the report would provide strategies for remediation and recommendations for promotion of age-appropriate skills, had been met. However, one parent had anticipated a personalized programme with specific therapeutic activities and had not received this.

The recommendations section of the reports from the speech pathology clinic were considered by most parents to be inadequate. Specifically, parents commented that the recommendations had been too brief, impractical, and not useful. One parent reflected this finding by commenting

> Well...I didn't find it very helpful. It was just a matter of...this is the recommendation, two lines...and I just thought that there could have been a bit more...recommendations here that maybe I could have passed down to the teachers.

Most parents from the speech pathology clinic commented that, although the report had outlined their child's difficulties, it had not helped them to assist their child. All parents expected the report to have outlined more specific recommendations for their child, including therapeutic directions, and strategies for the parent and school to implement. Each parent stated that they had wanted practical suggestions or exercises they could have completed at home with their child. One parent commented, "... it doesn't say much else apart from the results...it doesn't say this is what we think... should happen or anything like that. It doesn't tell us what to do". Two speech pathologists commented on the importance of including functional recommendations in the report. One noted the importance of providing suggestions or strategies to be implemented in the home and school environment and another made the comment that "parent and teacher reports need to have a very functional slant". However, none of the speech pathology reports had actually included functional recommendations. Two of the 3 occupational therapists identified recommendations as an essential feature of a report, noting the need to "... outline the results of a child's assessment in a way that explained (1) the problem; and (2) the remediation ...". Nine of the 10 occupational therapy reports reviewed included several practical strategies applicable to school and home tasks.

Parents from the speech pathology clinic commented that the recommendation of therapy, as stated, had been insufficient. Most parents reported that, although helpful in that it had illustrated that their child required further intervention and assistance, this recommendation had not assisted the parent in knowing what they could have done to help their child. In addition, the parents from the speech pathology clinic stated that although intervention at the university clinic had been recommended, they had needed more information on the number of sessions required per week, the cost of attending the clinic, and what aspects of the child's speech or language would have been targeted.

Parents from both clinics noted that they had wanted the report to outline more options for therapy, for example, private therapy or a more structured home program. One parent said

> We felt like there was nothing else that could be done except go to the university...cause there's nothing else there to tell us otherwise. And we've done all this work to get him to where he is now and our only option now is to go to the uni, that's it. End of story. And that was disappointing.

In cases where occupational therapy reports had included a variety of options for further intervention, parents had indicated satisfaction. However, a number of suggestions were still made to improve the utility of recommendations for intervention. These included providing common recreational activities appropriate to the family's daily routine, an explanation of how tasks related to the child's performance difficulties, and a detailed plan specifying the expected duration of the home programme.

The relationship between the assessment session and the report

For all parent participants, understanding of the written report had related to how much information they had received from the therapist on the day of the assessment. Parents who had been provided with a detailed explanation at the time of the assessment noted that this had aided their understanding of the report. For example, one parent said

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> She [therapist] explained what it [the testing] was for. . .so that we knew what was happening. . . and it was helpful so I could understand what was going on, otherwise, I would have been sitting there thinking 'oh god what is going on with all those sounds' and I wouldn't have understood the report.

Some parents commented that an explanation of the purpose and rationale behind the assessment would have enhanced their understanding of the report content. These parents noted that a detailed explanation at the time of the assessment would have allayed any fears they had concerning the assessment process and their child's performance. One parent noted that because she had been unsure of the relevance of the selected assessment tools, she had not felt that the assessment or subsequent written report had addressed her initial concerns, and thus had not found the results or recommendations included in the report helpful.

One parent who received a verbal summary of her child's test performance at the conclusion of testing found that this had aided her understanding of the subsequent written report. She noted

> They actually gave us a brief rundown of what the report was going to say. They quickly explained what they found . . . not so much the results, but why they were done, and then when we got the results we probably understood it a bit better . . .

Two therapists commented on the importance of including in the report a rationale for the tests used in the assessment. A further three therapists identified the need to provide parents with an explanation of the assessment process at the assessment session, including information about the tests used, the purpose of particular test items in relation to the child's functional performance, preliminary feedback of assessment results, and an estimated time frame regarding when the report would be completed.

Readability of the report

Three specific aspects of the report were considered by parents to be integral to their understanding of the report content. These were the use of profession specific terminology, the layout of information, and the length. A number of suggestions were provided by parents and therapists to improve the readability of the report. Participant responses are outlined below according to these three areas.

The use of profession specific terminology. Review of the reports indicated that most reports contained profession specific terminology that was difficult for parents to understand. A sample of the many terms identified by parents as limiting their comprehension included: ''ATNR inhibiting posture'', ''proprioception'', ''vestibular processing'', ''motor planning'', ''fine motor'', ''spatial relations'', ''visual motor integration'', ''normal visual pursuits'', ''deficits'', ''oromotor'', ''phonological awareness'', ''articulation'', ''blends'', and ''sound-letter conversion rules''. Abbreviations of test names such as CELF, QUIL, and TOLD also made the report difficult to understand.

Although this profession-specific terminology featured in the majority of reports, some parents from the occupational therapy clinic indicated that their reports contained limited jargon. They reported that, when jargon was used, it was accompanied by appropriate explanation. These parents described the content of reports as straightforward and thorough, and the writing style as professional but easy to understand. They perceived the information as non-medical, contributing to the ease with which the report read. Parents felt able to decipher terms independently, using the information provided. One mother, ''. . . believe[d] that the level of information hit the right mark overall because it talked about terminology . . . but it gave an explanation of any terminology and it didn't go into so much depth that it was overwhelming . . .''.

Most parents from the speech pathology clinic stated that they guessed the meanings of unfamiliar words, but because most of the reports had not contained an explanation of these terms, they were unable to verify their guess. One parent said

> I mean, my husband looked at that and just put it back down and said; well what the hell did that mean. Like he didn't go through school and he just found that very hard to understand. He didn't understand any of that.

A number of parents noted that they had experienced feelings of inadequacy when they had not understood the report because they felt that they should have understood the terminology. Some parents acknowledged attempts by the speech pathologist to help the parent understand, however the explanations provided had still been inadequate. For example, one participant said, ''I mean, they have given me a good chance at understanding it, you know, with the bracketed things, like ah, this is what I mean, but it still wasn't clear enough''.

Parents from both clinics spent a lot of time analysing and interpreting the report, often reading it over and over again. Several parents admitted that, ''. . . the nitty gritty . . . needed to be read two or three times . . .'' to gain a better understanding of concepts. In addition, parents commented that the more difficult the report had been to understand, the less they had wanted to read it. One parent said

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> To have to keep going back to something and try and understand it and put it all back together again is an enormous chore ... the further on you get, the less you want to read it 'cause you're not picking it up along the way.

Other parents reported that when they had not understood a section of the report, they had simply disregarded that section. One therapist also commented that if the reader had found the report difficult to read they may not have persisted, stating, "... people can give up—see it as being out of their league and only a therapist can help their child".

In general, therapists supported the inclusion of profession-specific terminology. However, they recognized the need for, "a clear, non-jargon explanation of the term immediately preceding or following, for the benefit of the family and others reading the report". Therapists believed it was beneficial to include terminology in the report as this facilitated communication with other professionals and developed parents' understanding of their child's difficulties. One therapist stated, "... having a 'term' for a problem can be reassuring to a parent that it is a frequently occurring problem". Another therapist believed it was important to include profession specific terminology in reports, "so they [parents] can talk more meaningfully to other significant people".

However, parents' comments indicated that profession-specific terminology had not assisted their communication with others; rather it led them to perceive that the report had been written for another professional, such as a teacher or another speech pathologist. One parent said, "It's just not written like, for any normal person that's not studying speech pathology. They should write a version for you guys and write a version for us. Everyone would understand it then".

All therapists specified techniques they used to ensure information met the needs and educational level of the average parent. These included the use of "simple language" with concise explanations and examples to describe a child's behaviour, reference to both strengths and weaknesses of the child's performance, the use of a "gentle", non-threatening style of presentation, the use of examples to facilitate understanding, and the provision of clear, detailed explanations for all assessment results and recommendations. One therapist commented, "The intended audience affects the amount of jargon used, how much explanation of tests and scores is provided, recommendations and the amount of detail provided". Another therapist said, "Assuming my intended audience is primarily the parent, I would expect the contents to be clear and easy for the parent to follow"; and another, "I think the explanations are the most important". Analysis of the reports provided to parents in the study indicated that these techniques had been inconsistently used by therapists.

Parents made three principal suggestions to improve the readability of reports. Firstly, several parents from the occupational therapy clinic recommended that reports include clarification of how the skills assessed applied to everyday tasks and behaviours. Parents believed that a description of how the tests used in the assessment directly related to their child's difficulties, with examples of their child's test performance included, would have assisted them to better understand the assessment and monitor their child's skill development. One parent commented, "I also wanted [an explanation] at the end of each [section] – 'what this means for your child'... something in parent talk". Two occupational therapists noted the importance of relating information within the report to the child's function, to ensure reports are useful for the parent audience.

Parents' second suggestion for improved readability related specifically to assessment results. Several parents indicated that they had had difficulty understanding the meaning of scores and percentiles. One parent said

> I didn't know whether the score was 4 out of 10 or 4 out of 20 ... but it's not 4 out of 10 because you read on later that 7 to 13 is average, but it's too late. You've already in your head decided that he got 4 out of 10.

Some parents believed that the use of a performance rating system that interpreted scores as age equivalents would have improved their understanding of assessment results. These parents acknowledged that it might have been confronting to see their child's performance reported at a lower age equivalent than their chronological age. However, most perceived that such a rating system would have been easier for them to understand. It was believed that, if used with an explanation of the skill level expected for the child's age group, age-equivalency scores would have enabled parents to compare and contrast their child's development. Some therapists acknowledged that any scoring systems used should be clearly defined. One therapist noted that standard scores should only be included if they are meaningful to the intended recipient.

The third suggestion to enhance readability involved supplementing the written report with verbal feedback. Most parents believed that a verbal explanation in conjunction with the written report would have aided their understanding of the report and would have provided an opportunity to identify further questions or concerns. Five therapists also commented on the value of providing an accom-

panying verbal explanation. They believed that providing parents with an opportunity for ''verbal feedback'' would have facilitated comprehension of how the findings related to their child. One therapist noted that, ''as a clinician, I would ensure a verbal explanation accompanies any document''. Another therapist said, ''they (the reports) should be gone through, not just sent out, so you may check a parent's understanding''; and another noted that, without ''. . . personal contact, it (the report) will fade in importance''.

Layout of the report. Parents had been satisfied with the format of the reports, and had commented that it had met their expectations. Inclusion of a list of the assessments used at the beginning of the reports had been considered beneficial. Although the reports had been perceived to be well structured and organised, several parents saw a need for further definition of headings and sub-headings in order to improve readability.

One parent discussed the location of the summary of the child's strengths and weaknesses, routinely provided at the end of the report. The parent explained

> When I first read through it I felt a bit anxious because... there were small problems... and I was reading through it... thinking... this is a nightmare. But by the time I got to the end it wasn't anything of great significance.

This parent believed that inclusion of a summary of the child's difficulties and therapeutic needs at the beginning of the report would have quelled her initial anxiety. The parent could then have referred to the body of the report for explanation of observations and test results.

Although most parent participants had felt satisfied with the grammatical style used in the report, a number of comments were made in relation to spelling errors and the general writing style. Some parents had identified numerous spelling errors within the report, noting that these had affected the credibility and professionalism of the report. In relation to the style of writing used, one parent noted that sentences had been too long and complex, and had made the report difficult to comprehend. One parent suggested that the use of tables and bullet points might have improved the layout.

Length. The length of the reports reviewed for this study ranged from 2 to 8 pages, with an average of approximately 5 pages per report. Parents initially had felt overwhelmed by the amount of detail provided, suspecting they had ''uncovered a bigger problem'' than first presumed. Generally however, parents appreciated the detailed descriptions and comprehensive account of their child's behavior. All parents commented that although the provision of examples and detailed explanation of terms might have increased the length of the report, increased length would not have concerned them if it aided comprehension. They believed that extra explanations would have added to the readability of the report which, in turn, would have facilitated a greater awareness and understanding of their child's performance status. For example, one parent said

> It might make the document longer, but we'd understand it. I don't care if it was ten pages long as long as it was explained...I'd rather read two more pages and understand it than read two less pages and not have a clue.

Two occupational therapists considered that reports should be 3 to 4 pages in length. One therapist acknowledged uncertainty regarding determining an appropriate length for assessment reports. She stated, ''obviously too long is off-putting and overwhelming but too short doesn't allow for explanation of terms''.

Use of the report

Although the specific usefulness of individual reports varied for each parent participant, all parents had used their written assessment report as a source of education. Despite the issues with readability previously discussed, all parents and therapists agreed that the reports had aided parental understanding of the child's skills and difficulties. Most noted that this increased knowledge had facilitated the provision of assistance at home and school. Some parents noted that they had used the report as a basis for changing their interactions with their child. One parent said

> Instead of just being used to his speech and not saying anything, now I try to stop and say the word for him when I hear him say it incorrectly. If I'm made aware of it then I can help him more in just his day to day speech.

Most parents found that the report had confirmed their own or the school's concerns about their child's development. Some parents reported that they had already been aware of their child's difficulties prior to the assessment and felt that the report had served to confirm this knowledge and identify these problems in more detail.

Parents and therapists commented on the benefit of having a permanent record of assessment results. Parents noted that they had re-read the results and recommendations section of the report from time to time. One parent said

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I like to re-read things over and go over things at different times and at least when you've got a report you can do that. I know I've had other things done and you don't get any report and you come away and you think, what did they say and what was it and did he do well in this and things like that. So yeah, having it in writing is much easier.

Therapist participants agreed on the value of providing written information for parents, with one noting that, "Parents are often overwhelmed by verbal information at the time of feedback. The report allows them to go away, read it at their leisure, and hopefully gain some understanding of their child's problems".

In addition to using the report to enhance their own understanding, all parents had shared the report with others, to facilitate greater awareness of their child's abilities and needs. The extended audience of readers had included spouses, grandparents, other relatives and family friends, allied health professionals, and school staff (including class teachers, learning support teachers, and teacher aides). By passing the report on to others, parents had received further assistance and support. Two parents had used the report to demonstrate to teachers that their child's difficulties had been due to a legitimate impairment rather than inappropriate behaviour. One therapist acknowledged that reports may be used by parents to provide information to others, such as, "... the child's performance/skills and how these might impact on/interface with the difficulties a child is having at school/home, i.e. to help shed some light on why a child is struggling as a basis for helping".

The report also had been viewed by parents as a good starting point for future planning, with some parents stating that it had provided them with a focus for action. One parent noted that the report had "kick-started a number of processes", including arranging for additional help, such as private tutoring and extra homework assistance. Other uses included assisting school staff to work with a student, and enabling access to specialist support services, such as school-based occupational therapy or speech pathology intervention, or extra reading support. In some cases, the report had been used by the school to develop an Individual Education Plan for the child and for other children with similar difficulties. Therapists also commented on the use of assessment reports for educational purposes, and to "make suggestions about an appropriate course of action".

In contrast, some parents perceived that there had been no discernible benefit to giving the report to their child's teacher. Other parents believed that information in the report might even have had a negative impact on their child's involvement in the school system. These parents therefore had been reluctant to provide teachers with a copy of the report. As one mother explained

... The principal of the school was talking about how some teachers do have preconceived ideas on students when they start. I think that if [my child] had a more serious problem it would probably be very beneficial [to provide the teacher with the report], but our problems really weren't that serious. So there's no point in putting him behind the eight ball before he starts.

Discussion

The purpose of the present study was to explore therapists' perspectives on clinical report writing and to examine the usefulness and benefit of occupational and speech pathology reports for parents. A secondary aim was to develop specific guidelines for therapists on how these reports can be written to ensure they are beneficial to parents. The need for such a study arose from the dearth of literature concerning therapists' and parents' satisfaction with assessment reports. The findings have important implications for the quality of services offered by therapists and client satisfaction with these services.

The qualitative nature of this study expanded on previous research by focusing on the experience of parents and their identification of preferred features of reports. In addition, the study documented the perceptions of both consumers and service providers, thus allowing comparison and contrast between the intended purpose of reports and their ultimate outcomes.

Current service delivery promotes family-centered intervention. Three key issues have emerged from the current study to assist therapists to effectively apply a family centered philosophy in their report writing practices. These issues will be discussed under the headings: the role of verbal discussion to support the written report; ensuring beneficial outcomes from the report; and the impact of language/readability.

The role of verbal discussion to support the written report

In contemporary service delivery, written reports are viewed as a primary means of communication between families and therapists (Rafoth & Richmond, 1983). The current findings, however, suggest that therapists tend to assume that written reports are sufficient as the major source of information for families.

Parents indicated that their comprehension of reports was enhanced when adequate time was made available for verbal explanations at the time of

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assessment. This may be expected given that parents have a variety of preferred learning styles (e.g. learning from discussion rather than from written material) (Woodring, 2000). In addition, most parents, at the time of assessment, are learning about concepts relating to their child's abilities for the first time. Discussion together with verbal and written clarification of these concepts is therefore likely to be useful.

The results further suggest that verbal explanation was beneficial at two different stages: before the assessment, to explain the content and relevance of assessment items; and immediately following the assessment, to give parents a brief summary of their child's performance and possible areas of difficulty. Although detailed explanation of each assessment item was not considered necessary, parents appreciated a general description of the purpose of assessment tasks before the assessment. Explanation of assessment findings after the session appears to be useful in helping parents know what to expect from the report and assists in their subsequent interpretation of the document.

It is possible that therapists may prefer not to provide an immediate verbal interpretation of a child's assessment performance. Possible reasons include the fact that standardized assessment will usually need to be scored following the assessment session, and the therapist may not have the time to complete this process while parents wait. Second, therapists may be reluctant to commit to an interpretation of the child's performance until all the assessment information has been collated and reflected upon. Despite this possible reluctance, it would appear useful for therapists to develop their skills and confidence in providing immediate verbal feedback on the child's performance in a manner that is both informative for the parent and accurate from the therapist's perspective.

Given the identified benefits of discussing the report with parents, it is likely that discussion may also assist others (such as teachers) in their interpretation of the report. The findings suggest that teachers may or may not act on the report's recommendations when they are only provided with the written document. Other research indicates that direct contact between therapists and teachers is more successful in increasing teachers' understanding of the child's needs than a report alone (Scott, 2001). Accordingly, the report can be seen as a means of initiating or extending contact between therapists and teachers rather than as the predominant means of relaying information about the child.

It is evident from parent responses in this study that families have a range of needs regarding explanation of assessment results. For each family, the time allocated for verbal discussion, the depth of information provided, and the language used throughout discussions requires consideration by the therapist.

Ensuring beneficial outcomes from the report

Earlier authors specified that information provided to parents must be useful, relevant and specific to the child (Isett, & Roszkowski, 1979; Tallent, & Reiss, 1959a). More recent literature also has advocated that therapists' comments should relate to difficulties experienced by the child (American Occupational Therapy Association, 1986; Rafoth & Richmond, 1983; Thompson, 1997; Weddig, 1984). The expectation that parents will implement suggestions provided in reports assumes that parents have gained an understanding of the implications of their child's difficulties. However, the current study indicates that if parents are to have a thorough understanding of their child's difficulties, therapists need to revise the way assessment findings are reported.

Analysis of the data revealed a discrepancy between therapists' descriptions of children's difficulties, and parents' desire for a practical interpretation of the results. Although therapists placed greater emphasis on detailing the child's skills, parents sought an explanation of the functional importance of their child's current and future difficulties. A report that primarily summarises test results and provides a list of recommendations is limited in its usefulness to parents. This style of reporting requires parents to make their own interpretations about test findings. Rather, in addition to reporting standard scores and percentile ranks, the report needs to provide parents with an individualised and practical interpretation of the child's test scores and how these relate to the child's personal, educational and social needs. A clear explanation of how a particular test finding may manifest in everyday activities would be beneficial and useful. Findings need to be linked to activities in which the child is currently involved or to tasks appropriate to the child's development.

For example, instead of: "William achieved a standard score of 3 on the *Recalling Sentences in Context* subtest" the result could be expressed as: "William's standard score of 3 on the *Recalling Sentences in Context* subtest (where 7 – 13 is average) suggests that William may have difficulty remembering and following the teachers' instructions in class. He may need instructions broken into small steps with key words emphasized and with one, two, then three fingers held up corresponding to each part of the instruction".

Information about the child's ongoing and/or future needs may include an explanation of how the child's difficulties may lead to future problems. This information may assist the parents and school in

anticipating possible difficulties and putting strategies in place to minimize their impact. For example:

''Although Ethan is meeting handwriting requirements in class at the moment, increased handwriting demands in future years may result in him having more difficulty finishing his work. If this becomes an issue, it may be useful to consider alternatives to handwriting for longer pieces of written work (e.g. typing, getting copies of notes)''.

All parents in the study indicated that they had shared the report with others, including relatives, friends, and other professionals working with their child. A well-written report that clearly outlines the functional implications of the test results is likely to lead to a more effective interpretation and common understanding of the child's difficulties and needs for all readers. The use of reports by school staff when developing an Individual Education Plan for the child would also be greatly enhanced by a report that clearly transfers findings into functional implications.

Following a clear and functional interpretation of the child's test performance, the next step in meeting the needs of children and parents is the provision of practical and realistic recommendations targeting the child's areas of difficulty. The importance of this section to parents cannot be overstated. Parents anticipate individualized suggestions that they can easily implement. Such recommendations are best devised on a case-by-case basis, with consideration of the family's daily routine, time available, and the skill and confidence level of the parent. Therapists could also provide a rationale for these strategies and specific information about how to implement them.

When recommending therapy, therapists may provide details about where and how parents can access specific services, information about costs and waiting periods, and the variations in service delivery approaches across agencies. Recommendations for therapy could also include information regarding skills that could be targeted and therapeutic approaches to be used. A long-term plan of action including the need for follow-up, review appointments, and liaison with school personnel could be proposed. Consideration by therapists of the above may result in increased parental understanding of the report and greater parental involvement within the therapeutic process.

The impact of language/readability

The findings of this research confirm that the use of profession-specific terminology reduces readability of reports. This result is consistent with the findings of Cranwell and Miller (1987) and Flynn and Parsons (1994). However, therapists appear to be reluctant to replace jargon with simple explanations and lay terms. The current research revealed a discrepancy between therapists' and parents' perceptions of the benefit of jargon. Occupational therapists and speech pathologists stated a general preference for the use of profession-specific terminology to aide parents' communication with other ''significant'' people and to ensure parents' understanding of their children's difficulties. In contrast, parents found jargon limited their understanding of their child's assessment results. The resultant feelings of inadequacy described by parents may hinder their willingness to communicate with professionals. Thus, therapists' use of jargon may be serving to exclude parents from the therapeutic process, jeopardizing the family-centered philosophy to which they aspire.

It appears that reports are of greater use when profession-specific terminology is accompanied by a clear interpretation. This study identified that reports containing simple explanations of jargon terms were considered by parents to be professional, straightforward and readable. In contrast to findings from earlier research (Pannbacker, 1975), this study also found that longer reports were acceptable, provided they contained detailed explanations that facilitated a better understanding of the child's difficulties. Hence, the use of jargon need not be problematic if it is accompanied by clarification of terms. The language used needs to be tailored to families' needs. Knowledge of parents' level of understanding of therapy services will assist therapists to individualize the use of terminology and the explanations provided.

The same principle applies to reporting of assessment scores. Parents indicated that standard scores and percentiles should be put in context—for example, stating the average range whenever a score is reported. Given that the parents' overriding need is to place their child's performance in relation to peers, standard scores and percentiles could be used if accompanied by adequate information. Some parents believed that reporting age equivalents would give greater meaning to their child's assessment results. However, this carries the risk of misinterpretation if the age equivalent score is viewed globally rather than as skill-specific. Additionally, for some parents and older children, the reporting of age equivalent scores may cause distress if it is perceived that the child is functioning at the level of a much younger child.

Implications for practice

This study has identified that parents have a preference for particular features in the reports they receive from therapists. The finding that occupational therapy reports were seen as more readable

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and useful than speech pathology reports is likely to reflect the difference between the key features of reports in the two clinics. For instance, the occupational therapy reports placed more emphasis on a functional interpretation of assessment results together with a specific plan to address areas of difficulty.

While therapists may be aware of the desirable features of reports, they do not consistently apply them. Results of this study revealed a mismatch between therapists' intentions when writing reports and their actual practices. This suggests that specific guidelines and processes are required to assist therapists to produce reports that are accessible and useful to families. The occupational therapy clinic had already provided therapists with an example report, and this may have assisted the therapists.

Results suggest that report guidelines need to encourage therapists to individualize information for each family, according to the child's functional performance and daily routine. Therefore, it is suggested that therapists avoid the use of report proformas in which assessment results are simply slotted into predetermined categories. Of greater assistance to therapists would be guidelines which:

(1) Include a bank of lay explanations for commonly used professional terminology. For example:
"Visual motor integration refers to the taking in of information visually, then using this information in order to plan our movement. For example, looking at a letter, then planning where we want to move our pencil in order to write that letter. Visual motor integration impacts on one's ability to reproduce numbers and letters accurately, to color within lines, and to trace."
(2) Give examples of how specific assessment results can be made more meaningful to parents and teachers by applying them to relevant functional tasks with which the child has difficulty. For example:
"Thomas' difficulty using referencing on the Renfrew Bus Story, suggests that he may have difficulty expressing his ideas clearly in conversation or when telling stories to unfamiliar listeners. Thomas should be encouraged to think about addressing 'who, what, when, why, and how' to give his stories structure and to make them clearer."
(3) Prompt the therapist to include specific recommendations and plans for further intervention, perhaps by means of a checklist of possible details to include. For example:
Ensure the report includes information where relevant regarding
   - Whether therapy is required
   - Where this could occur
   - Who will initiate the process of organising therapy
   - What therapy will involve/main areas that will be addressed
   - If other services are recommended e.g. school visit, review, etc.
   - Ideas for home and school that could be immediately used with the child OR state that a home program is to follow
(4) Prompt the therapist to include reference to future implications of the child's difficulties where applicable. For example:
"Patricia's memory difficulties mean that she may need to develop strategies for learning new work. For instance, she may benefit from creating rhymes or songs to help her remember particular spelling rules."

Limitations and directions for further research

Four possible limitations of the study have been identified. First, the relatively small number of therapist and parent participants consulted may be perceived as a limitation, however Gliner (1994) and Krefting (1991) have argued that this criterion for rigorous research is not critical to the qualitative paradigm. Due to the naturalistic design of the investigation, and the intention of exploring a diversity of attitudes regarding the topic studied, a larger sample is not necessary.

Second, the limited contact between the researchers and parents may have lead to reluctance on the part of the parents to disclose more controversial attitudes. Third, several parents commented that the 6-month period since their child's involvement with the clinics impeded their memory of their initial reactions to the reports. Finally, it is possible that the involvement of students in the clinics may influence the quality of reports produced. For instance, a student's level of understanding and skill may influence the amount of jargon used, the content covered and the clarity of explanations provided. However, therapists working in the university clinics are ultimately responsible for the quality of reports, and students are therefore assisted to produce reports of a professional standard. Importantly, parent participants did not comment on the possible impact of student involvement in the report writing process.

Further research in this area is warranted and needs to address the above limitations. Future research could consider the issue of clinical reporting from the perspective of schoolteachers and other recipients of allied health reports. There is also a

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need for further research evaluating parent satisfaction with the assessment process in particular.

Conclusion

This study highlights the practices required to produce reports that are readable and beneficial to parents. It appears that report writing is not a skill that therapists acquire automatically. Effective family-centered intervention demands that report writing skills are prioritised, practized and refined. Given that clinical reports are the most enduring record of therapy contact, and have the potential to effect positive outcomes for children and families, greater attention to this area of practice is required.

Acknowledgments

The authors wish to thank the participating parents and therapists who willingly gave their time for interviews and questionnaires. The assistance of the participating clinics is also appreciated.

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