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Occupational Therapists' Perceptions of Intraprofessional Collaboration When Working with Young Children Aged Birth to 3 Years

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Occupational Therapists' Perceptions of Intraprofessional Collaboration When Working with Young Children Aged Birth to 3 Years

Abstract

Background: Birth to 3 years of age is a critical period in a child's development, and occupational therapy intervention during this period can serve many purposes. While pediatric occupational therapists may be working in different settings with different specialties, the foundational knowledge all occupational therapists possess provides a common lens through which they approach treatment. Intraprofessional collaboration is considered best practice, as it is not uncommon for young children to receive occupational therapy services by more than one therapist, and in more than one practice setting at the same time.

Method: This study used a qualitative, phenomenological approach. Data was collected through semi-structured interviews.

Results: Following thematic analysis, five themes emerged from the data with regard to intradisciplinary collaboration. They include (a) the discrepancy between best practice and actual practice, (b) systemic differences between practice contexts, (c) varying perceptions of competency, (d) the impact of therapists' professional boundaries and behaviors, and (e) the role of the parent/caregiver on the intradisciplinary collaborative process.

Conclusion: All of the participants were able to define and express the value of collaboration. The therapists reported that contributing variables that either facilitate or pose barriers to intraprofessional collaborative relationships are individualized and include communication style, motivation, and the need for system advocacy.

Comments

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Keywords

collaboration, early intervention, occupational therapy

Credentials Display

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Birth to 3 years of age is a critical period in a child's development (American Occupational Therapy Association [AOTA], 2015; Myers & Cason, 2020; Opp, n.d.; U.S. Department of Education & U.S. Department of Health and Human Services, 2017). All young children and their caregivers should have access to coordinated and comprehensive services that support development, health, and wellness. One type of support provided to children from birth to 3 years of age is referred to as Early Intervention (EI) services through the most accessed federal program, Part C of the Individuals with Disabilities Education Improvement Act (IDEA) (AOTA, 2015; Centers for Disease Control and Prevention [CDC], 2019; Myers & Cason, 2020; U.S. Department of Education [USDE], 2011, 2017). Related service providers, such as physical therapy, speech and language pathology, and occupational therapy, work with this population of children and their families through local, state, and federal programs (Myers & Cason, 2020).

EI services can serve many purposes, such as supporting the development of young children with disabilities and supporting the capacity of families and caregivers to meet the needs of their young child by engaging in intentional, respectful interactions with family and team members (Division of Early Childhood, 2020; Myers & Cason, 2020; Opp, n.d.; USDE, 2017). EI programs and services through IDEA may occur in a variety of settings, with a preference for natural environments (CDC, 2019; Myers & Cason, 2020; Seruya & Garfinkel, 2018; USDE, 2011, 2017). Young children may receive occupational therapy early intervening services, as opposed to EI, in other settings that do not fall under the umbrella of IDEA, as well. Such occupational therapy services are frequently more medically based and are provided in settings such as neonatal intensive care units, hospitals, and outpatient clinics (AOTA, 2014). Regardless of the practice setting, partnering with families and engaging in collaboration with other professionals involved in the care are considered to be best practice when working with children aged birth to 3 years (AOTA, 2020a; Myers & Cason, 2020; Opp, n.d.; USDE, 2011).

A more collaborative approach provides a more coordinated and consistent treatment model for the child. While pediatric occupational therapists may be working in different settings with different specialties, the foundational knowledge all occupational therapists possess provides a common lens through which they approach treatment. The Person Environment Occupation Model (AOTA, 2020a; Law et al., 1996) provides a link between the child, their occupations, and their environments. An occupation such as play can occur in a variety of environments. A child's skills may present differently, depending on his or her environment. Collaborating with an outside occupational therapist who is working on similar occupational needs can assist in providing a clearer understanding of that child. Occupational therapists who engage in a collaborative relationship when working with the same child help to reduce potential redundancies of services and ensure the intervention provided is necessary (Hanft & Swinth, 2011).

The *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2020a) is used by occupational therapists to guide them in their practice when working with children aged birth to 3 years. Interventions may include developing skills, restoring movement, creating and/or maintaining access to various occupations, and modifying and adapting the environment and/or occupation (AOTA, 2020a; Clark et al., 2017). Providing client-centered and family-centered care using evidence-based practices is central to occupational therapy practice (Clark et al., 2017). As a related service available to young children and their families under Part C of IDEA, EI services allow occupational therapists to provide services to this population of children and their families in a variety of natural contexts including, but not limited to, family homes, daycare, and other community-based settings (Arbesman et al., 2013; Laverdure et al., 2016; Myers & Cason, 2020; USDE, 2017).

It is not uncommon for young children to receive occupational therapy services by more than one occupational therapist and in more than one practice setting at the same time (Arbesman et al., 2013; Nolan et al., 2007). For example, a 2-year-old child may receive occupational therapy EI services in their home to address play skills and the establishment of a bedtime routine, while at the same time, they may be seen by an occupational therapist in an outpatient clinic to implement a program focusing on bimanual hand skills or to fabricate and integrate the use of a hand splint to be worn at night. A lack of coordination between therapists with regard to the provision of care has been reported to result in fragmentation and gaps in service, as well as duplication in care (Ideishi et al., 2010; Nolan et al., 2007).

Collaboration is the interactive process that focuses teams on enhancing the functional performance, educational achievement, and participation of infant and toddlers with disabilities in community and home environments (Hanft & Swinth, 2011). Collaboration is a key component of AOTA's Vision 2025. One of the pillars essential to Vision 2025 is collaboration, as occupational therapists excel in the work they do with individual clients and in larger systems to bring about effective change (AOTA, 2020b). Collaboration occurs between individuals from different professions (interprofessional collaboration) as well as those in the same profession (intraprofessional collaboration) (World Health Organization [WHO], 2010). When professionals demonstrate effective collaborative reciprocity, best practices in therapy provision are communicated, planned, and carried out with intentionality (James & Walter, 2015; Scheerer, 2001; Watling & Jones, 2018). Collaboration is essential when providing the complex care often associated with children between birth and 3 years of age (Clark et al., 2017; Del Rossi et al., 2017).

According to AOTA's Workforce Study, occupational therapists spend less than 5% of their time in consultative collaboration (AOTA, 2015). Collaboration among various stakeholders is deemed best practice in EI (AOTA, 2020b; Clark et al., 2017; Del Rossi et al., 2017; Hanft & Swinth, 2011); however, EI occupational therapists have reported feeling isolated and identified collaboration as an area in need of improvement because of a lack of opportunity and/or time (Bowyer et al., 2017). Collaboration across settings and systems poses additional challenges, such as access, coordination, and provision of services (Corr & Santos, 2017). Occupational therapists who engage in an intraprofessional collaborative relationship when working with the same child help to reduce potential redundancies of services and ensures the intervention provided is necessary (Hanft & Swinth, 2011). Bowyer et al. (2017) reports that while there is clear value to occupational therapy when treating children from birth to 3 years of age, there is limited qualitative information on the lived experience of occupational therapists. In the occupational therapy profession there is literature regarding interprofessional collaborative practice (Accreditation Council for Occupational Therapy Education, 2011; Interprofessional Education Collaborative, 2016; WHO, 2010); however, there is a paucity of literature regarding intraprofessional collaboration beyond that of an occupational therapist and an occupational therapy assistant.

This study addressed the question, What are the experiences and perceptions of occupational therapists working with children aged birth to 3 years regarding intradisciplinary collaboration? The purpose of this study was to explore therapists' perceptions of the intraprofessional collaborative process that occurs between occupational therapists when multiple occupational therapists work concurrently in different contexts with children aged birth to 3 years.

Method

Research Design

This study used a qualitative, phenomenological approach. This approach was selected to capture an individual's perceptions of an event or phenomenon (Matthews & Kostelis, 2011). The primary method of data collection was semi-structured interviews. Each participate answered the same questions and had the opportunity to elaborate based on their own experiences (Matthews & Kostelis, 2011). The interviews took place via teleconferencing and were analyzed for common themes.

Participants

The participants for this study were recruited via social media, professional networking, and snowballing. Individuals were sought from a variety of practice settings, including hospitals; community-based settings, such as nursery schools and daycare; familial homes; and private clinics. Each of these practice settings have specific service delivery approaches based on their model of care. Inclusionary criteria included occupational therapists and occupational therapy assistants who had treated a child between birth and 3 years of age who was also receiving occupational therapy services concurrently using another practice setting by a different occupational therapists in the US within 6 months of being recruited. All of the participants that were recruited met the inclusion criteria. Refer to Table 1 for additional demographic information.

Table 1

Participant Demographics

Pseudonym	Degree	OT/OTA	Experience	State	Practice Setting
Jennifer	Masters	OT	17 years	NY	Homecare, EI
Mary	Masters	OT	11 years	NY	Preschool, EI
Caroline	Masters	OT	16 years	NY	Homecare, EI
Meredith	Masters	OT	14 years	CO	Hospital
Eloise	Masters	OT	6 years	CA	Hospital
Andrea	Bachelors	OT	27 years	ME	Private clinic
Jillian	Masters	OT	10 years	AL	Homecare, EI
Maggie	Masters	OT	6 years	NJ	Clinic
Elle	Masters	OT	9 years	NY	Hospital
Abigail	Doctoral	OT	32 years	CT	Private clinic

Semi-Structured Question Development

The semi-structured questions were developed based on information obtained from a comprehensive literature review. It should be noted that the operational definitions in Table 2 were provided to the participants at the time of their interviews. Refer to Table 3 for a list of semi-structured interview questions used during the interviews.

Table 2

Operational Definition of Terms for the Participants

- The term **child** will refer to anyone aged birth to 3 years.
- A **different practice setting** refers to any setting outside your own, such as medical or home based.
- An **outside occupational therapy practitioner** is concurrently treating the same child as you in a different practice setting.

Table 3

Semi Structured Interview Questions

1. "What is your own definition of collaboration in your practice and between other occupational therapists?"
2. "Can you tell me about the types of opportunities you have to collaborate with other occupational therapists at your place of employment (case studies, journal clubs)?"
3. "Do you feel it is important to collaborate directly with an occupational therapist who is treating the same child as you? Why? Why not?"
4. "Has it been your experience that there is collaboration between occupational therapists?"
5. "Can you tell me how confidentiality laws may facilitate or hinder collaboration in the plan of care of a child with outside occupational therapists?"
6. "When trying to collaborate about the plan of care of a child with an outside occupational therapist, what methods of communication do you find to be most effective (phone call, email, face-to-face, etc.)?"
7. "How do you generally feel when a child is receiving additional occupational therapy services by an outside occupational therapist?"
8. "Can you tell me about how it is decided how often collaborations happen and how often you are able to sustain consistent collaboration?"
9. "Can you tell me about things you have experienced that have been facilitators to collaboration with an outside occupational therapist?"
10. "Can you describe some benefits to a child receiving services by multiple occupational therapists in multiple settings?"
11. "Can you tell me about a successful collaboration you have had with an outside occupational therapist (outside your place of employment) regarding evaluation, goal setting, or plan of care of a child?"
12. "What are some of the things that get in the way of collaborating with an outside occupational therapist?"
13. "Can you tell me about a time when you might not have been available to discuss the care of a child with an outside occupational therapist?"
14. "Has there ever been a time when an outside occupational therapist was not available to discuss care of a child with you?"
15. "Can you tell me about a time you felt there may have been conflicting or duplication of occupational therapy services?"
16. "In your experience, what role does the parent play, if any, when there are two occupational therapists from different settings working with their child?"
17. "In your opinion, what do you think could be done to increase collaboration between occupational therapists?"

Data Collection

To increase the validity of the semi-structured interview questions they were piloted by four occupational therapists who were not participants in this study. They reviewed the questions to ensure focus was on the intended content. As a result of this review, questions were reorganized for improved conversational progression of topics (Matthews & Kostelis, 2011). All of the interviews were audiotaped and transcribed verbatim. Transcriptions were completed by either the researcher that conducted the interview or a transcription company. Word documents were kept on the password-protected computers of the primary and co-investigators, and no identifying information was used on these files.

Each interview began with a brief definition of specific terms that would be used throughout the interview for clarity. The participants were encouraged to ask questions as needed and could withdraw or stop the interview at any time. Brief demographic questions were asked prior to the semi-structured interview regarding their experiences collaborating with outside therapists who are working with the same child aged birth to 3 years at the same time.

Data Analysis

Data was analyzed and coded for recurring themes and categories. To increase the rigor of findings in this qualitative study, the triangulation strategies of member checking and peer debriefing were used. Member checks for this study included sharing summarized information obtained from the actual interviews of two participants to ensure that intent and meaning were aligned between the two participants and the interviewer. Additional member checks did not occur secondary to time constraints of the study. Peer debriefing for the study included the use of two peers not immersed in the data to allow for an objective view in order to clarify interpretations and meanings determined by the primary researcher (DePoy & Gitlin, 2016).

Triangulation of the data occurred to improve trustworthiness. This was accomplished via peer debriefing and member checking. Peer debriefing occurred by using a reviewer, who was not involved in the information gathering process, to clarify interpretations of the data made by the interviewer and to offer alternative perspectives on the information collected (Matthews & Kostelis, 2011). The primary investigator collaborated with the co-investigator for the purpose of reviewing the data obtained from the interviews and organizing it into meaningful codes to be analyzed.

Results

The purpose of this study was to explore the perceptions of intradisciplinary collaboration of 10 occupational therapists. Five themes emerged from the data with regard to intradisciplinary collaboration. They included (a) discrepancy between best practice and actual practice, (b) systemic differences between practice contexts, (c) varying perceptions of competency, (d) impact of therapists' professional boundaries and behaviors, and (e) role of the parent or caregiver on the intradisciplinary collaborative process.

Theme I: A Discrepancy Exists Between Best Practice and Actual Practice

The participants' perceptions of intraprofessional collaboration revealed there is a discrepancy between best practice and actual practice. All of the participants noted intraprofessional collaboration provides value to identifying goals, setting a treatment plan, and/or ensuring approaches used are complementary. The participants reported intraprofessional collaboration allowed "everyone to work from the same page." One participant reported it allowed occupational therapists to "plan together for who is going to address what." The respondents further stated collaboration afforded them the opportunity to "discuss and brainstorm ideas, treatment interventions, strategies about a patient." However, it was also noted the establishment and continuation of a collaborative relationship was not always easy to achieve.

The participants reported initiating contact at the start of care; however, continued contact was inconsistent. Eloise, a hospital-based occupational therapist stated, "I don't feel like I am able to sustain a consistent collaboration." The participants expressed high caseload numbers were a barrier to establishing the collaborative relationships that they value. Eloise expressed "it's not built into our schedule to be able to have time to follow up on these things."

Theme II: Systemic Differences Between Practice Contexts

Contextual differences between practice settings affected how the participants were able to collaborate. The respondents identified productivity standards and communication policies as variables that acted as facilitators or barriers to intraprofessional collaboration. It was consistently reported that collaboration is not considered direct patient care and is not a billable service. The participants indicated the overall system they work in dictated their time usage and work-related expectations. The participants expressed collaboration "is not viewed as productive time, and I do not receive support from my employer to do it." Meredith stated, "everybody has to see a lot of patients, do a lot of paperwork and everyone is spread thin, so it is a conscious effort that you have to make to make it a priority to collaborate." When asked about allotted time for collaboration, one responded stated, "instead of writing my notes, I can use it for phone calls and then the note writing will be on my own (time)." While some of the participants reached out with an email, Eloise noted the use of secure or encrypted emails have been unsuccessful: "I don't get any response back. And I don't know if it is because they don't want to log in or if it's a hard time. But I haven't actually had a response to those emails."

Confidentiality played a role as well in the collaborative process, as reported by the participants. The method of receiving consent varied by setting. Jillian reported, "sometimes either a parent won't sign (consent) over that information or sometimes it just takes too long to get it signed or faxed over or whatever the case may be, and it slows down the process." Some therapists reported using the initial evaluation to establish consent to speak to outside therapists. Abigail, a clinic-based therapist with over 30 years of experience, stated that once a caregiver mentions a new team member, she will ask for consent to speak to them.

Theme III: Perceptions of Competency and Experience

While occupational therapists were frequently aware that the child they are treating was also receiving occupational therapy services by another occupational therapist to supplement or provide a different approach to therapy, assuming ownership of collaborative responsibilities was reported to be impacted by the perception of competency and experience of the therapist with whom they were collaborating. Caroline stated that when something is "outside of my scope of what I can do it's important to get someone who knows what they are doing." At times, it included educating the other therapist on a technique or strategy they might not be familiar with; however, the relationship was not reciprocal as per report. For example, a home-based therapist indicated splinting as "totally outside of my scope of what I can do so it is important to get someone who knows what they are doing," relying on the hospital-based therapist to handle this aspect of treatment. Frequently, the participants noted a bias in their perceptions of outside therapists related to where they worked and their experiences. For example, one participant noted "sometimes they're hesitant about their own skills so it's easier to stay in your own zone." The participants said that although their relationship with another occupational therapist may have begun as a consultation, wherein the "expert" occupational therapist provided education to them, as their relationship evolved, the roles became more fluid, with each of them learning and problem-solving together.

Theme IV: The Impact of Professional Boundaries and Behaviors on the Collaborative Process

Each participant identified their own professional boundaries and behaviors that impact their ability to initiate and form collaborative relationships with outside therapists. Some of the participants reported using non-business hours to collaborate with other occupational therapists. Abigail acknowledged, "but you know, some people have their lives, so they set clear boundaries on what is their workday. And you can't fault them for that." However, this was not consistent for all of the participants. Eloise stated, "I do not use my personal phone for calls to parents or the outside therapist so anytime for me to collaborate would be during work hours." The participants noted that being flexible with their time or methods used to communicate with outside therapists often lead to more successful collaborative relationships. Others expressed the need to be persistent, using various forms of communication to reach out to therapists until there was a response. For example, Maggie indicated that when trying to call outside therapists to receive a response she will usually "kind of call them relentlessly."

Of the different methods used to communicate, all of the participants stated that in-person, face-to-face meetings were the most beneficial. Abigail stated, "show right then and there what is the facilitation or how are we encouraging it." However, the participants noted in-person meetings can be a "logistical nightmare." It was reported that the use of the telephone allowed therapists to "elaborate more, hear tones of voices and you can ask questions based on other questions, and it goes faster." This was also reflected by Mary, when she said conversation allows the therapist to "hear in their voice what they're saying, if there is hesitation with an answer … you cannot get that in a carefully scripted email." Email was identified as the most convenient, "when you have 5 min at the computer you can quickly type out an email or at the end of the day and you don't have to feel like you're wasting 10, 15 min on the phone. You are doing 2 min in an email." Conversely, Jillian stated, "when I'm doing EI I'm just not in the office … it takes several days for me to return those calls and emails and that can slow down the process of that collaboration." Many therapists provided examples of attempts to collaborate where they are reestablishing relationships each time of contact during multiple calls, emails, or having lengthy discussions with parents.

Theme V: The Role of the Caregiver

Some of the participants reported family support either facilitated or provided a barrier to collaboration. One respondent stated, "it's usually the parent that's pushing for us to collaborate." Maggie stated, "it's because the parents want us to talk … they want us to be on the same page, if they invest the time to take the child to the other provider, then they are good facilitators." Communication through a third party, like the parent, was also explored by the respondents. Jennifer stated, "I would have some initial conversation with the [occupational therapists], sometimes not even, but we communicate through the parents." Andrea cautioned using parents to assist with the share of information can put the "parent in more of an awkward position, especially if we are not on the same page." However, more often than not the participants stated that parents assist in updating therapists on the process and techniques used in other treatment spaces. Maggie stated she had experienced conflicting information between the parent and therapist where "the parent will be like, the kid is doing great, and the therapist will be like, we are making kind of minimal progress, or even kind of the other way around." It was reported by Abigail that some parents avoid collaboration: "they're fearful of the collaboration because then they have to come to grips with … there really are issues."

Discussion

Overview

The purpose of this study was to learn more about occupational therapists' perceptions of intraprofessional collaboration among occupational therapists when working with children aged birth to 3 years. In this section, the limitations of this study, the implications for practice, and opportunities for future research will be discussed.

Limitations of Study

The limitations to this study should be noted. The semi-structured interviews were completed over the telephone; therefore, body language, which might have been obtained from a face-to-face interview, was not observed. This might have yielded richer information about the participants' experiences and perceptions. While occupational therapy assistants were included in the recruitment, they were not represented in the sample, as none volunteered to be part of this study. The sample of participants spanned the US; however, most of the participants practiced in the Northeast. As the participant pool did not include occupational therapy assistants or male therapists and did not represent all areas of the US, it is possible that the perceptions of the participants in this study do not adequately represent occupational therapists working with children aged birth to 3 years across practice settings.

Implications for Practice

Contributing variables that either facilitate or pose barriers to collaborative relationships are individualized and reflect the relationship between personal and contextual factors as well as occupational demands. These contributing variables include communication style, motivation, and the need for system advocacy.

Communication Style

Communication preferences have been reported to be either facilitators or barriers to productive collaboration. It was reported that individual occupational therapists often select how or when they communicate with others based on setting, time, or personal style. Intentional pursuit of effective collaboration can be particularly important in cases where there is an overlap in scope of practice (Watling, 2020).

Strategies for Facilitating Collaboration. The participants in this study reported that working in the same setting naturally facilitates collaboration because of frequent opportunities to communicate and build relationships through shared office space, regularly scheduled meetings, and the accessibility of colleagues. These opportunities to build relationships naturally over time during the workday provide opportunities for therapists working in the same system. As some of the participants reported their communication methods did not align with an occupational therapist who does not work in their setting, it is recommended to ask and share preferred methods of collaboration to facilitate rapport building. A consistent method of communication or structuring attempts at collaboration can help increase efficiency and productivity between occupational therapists. This can occur through an emailed list of topics prior to a phone call or providing the occupational therapists a weekly form focusing on specific discussion points, including areas from the plan of care. Establishing a communication book, a notebook that goes with the child to all visits and in which each occupational therapists summarizes sessions, can foster relationships. Many of the respondents indicated that they preferred the use of verbal communication; however, coordinating times may be difficult. Using a voice message or live or recorded videos can be a helpful way to employ technology to establish a collaborative relationship. Knowledge of the consent and confidentiality policies of the practice setting that the occupational therapists is working in is critical.

Motivation

Findings of the study indicated the more motivated an occupational therapists is to collaborate with another occupational therapists, the greater the likelihood effective collaboration occurs. As the participants reported in the study, parent involvement either led to greater or less frequent intraprofessional collaboration. Moreover, motivation was often related to a therapist having a clear definition of their role in the child's treatment, especially when it differed from the other occupational therapist(s) who may be working concurrently with the same child in another setting. Further, inequity in relationships may inadvertently affect the dynamics of the relationship, creating the perception one occupational therapist may hold more power in the relationship than the other, thereby interfering with a true collaborative experience and negatively impacting on their motivation to collaborate. This perception may interfere with the initiation and/or development of collaborative efforts. As collaborative relationships take time to build, the participants need to be motivated to continue its development. As reflected in the literature, identifying the roles of each individual in a manner that defines and values the contributions of each team member enriches the relationship (Watling, 2020).

System Advocacy

The participants expressed increased levels of fatigue and being overwhelmed with high caseload numbers. This is consistent with the literature on current trends in pediatric practice (Garfinkel & Seruya, 2018; Seruya & Garfinkel, 2020). As a result of productivity standards across practice settings, many of the participants reported decreased support from employers to allow time for collaboration. Two of the participants were owners of a private clinic and continued to actively provide intervention services. Both acknowledged there is a limit to how much non-billable time they are able to provide to their employees; however, they do try to allot time for collaboration with outside therapists. For the other participants, who worked in the EI or the hospital setting, they expressed the system is set with limited opportunity for change. As intraprofessional collaboration is best practice (AOTA, 2020a; Clark et al., 2017), and it is reported that many therapists are not engaging in intraprofessional collaboration, advocacy efforts to provide therapists with time to collaborate with others would support best practice. As the participants noted, the system in which they practiced frequently had its own culture that impacted their use of time and resources for collaborating with other occupational therapists. As these variables were noted by the participants to be barriers to collaboration, there is a need for occupational therapists to advocate for system changes. Although many of the participants expressed frustration over a lack of system support, none of the participants reported plans to advocate for system changes. This frustration was expressed by occupational therapists that held varied positions in their systems and organizations, with some having more influence over the system than others.

An example of a way an occupational therapist might advocate for change would be to speak to their site-specific occupational therapist colleagues, gather data on the ways in which they are using their time, and use the data that demonstrates their common experiences to advocate for the ability to have time set aside to collaborate with others outside of their organization (Garfinkel & Seruya, 2018; Seruya & Garfinkel, 2020).

Recommendations for Future Research

There are several areas related to this study that can direct future research with the goal of supporting occupational therapists in forging collaborative relationships when working with children from birth to 3 years of age across multiple practice settings. Exploring family and caregiver perceptions of collaboration, other stakeholders' perceptions of interdisciplinary collaboration, and role expectations and

practice setting definitions within this population may direct improved relationships and reinforce family-centered and client-centered care. Further, while the literature indicates collaborative services provide improved care, goal attainment, and a decrease in a duplication of services (Ideishi et al., 2010), the results of this study did not demonstrate a link between what the literature shows and what is actually happening in practice. An area for future research would be to explore why current practice is not reflective of evidence-based practice.

As time was a consistent barrier to the occupational therapists, investigating time management issues between various settings, including the specific work expectations that prevent collaboration from occurring, would be helpful to explore. Further, given society's needs, the use of telehealth as a bridge to increase opportunities for collaboration should be explored.

Conclusion

This qualitative, phenomenological study explored how occupational therapists collaborate with one another across practice settings when treating a child between the ages of birth to 3 years. Five themes emerged from the data. They include: (a) the discrepancy between best practice and actual practice, (b) systemic differences between practice contexts, (c) varying perceptions of competency, (d) the impact of therapists' professional boundaries and behaviors, and (e) the importance of the role of the parent or caregiver on the intradisciplinary collaborative process.

All of the participants were able to define and express the value of collaboration. However, there was a discrepancy between best practice recommendations and actual practice. Many of the participants reported barriers, which prevented consistency and effectiveness of building true collaborative relationships. Across all settings the lack of funded time for indirect patient care and varying levels of personal sense of responsibility impacted a therapist's ability to collaborate. Occupational therapy is a vital service for children between birth to 3 years of age. Collaboration between practice settings by therapists provides best practice to ensure consistency, which supports development of a plan of care, continued progress, and goal attainment.

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