

# ***Accomplishing Innovation***

**Developing Early Intervention Services  
for Children with Special Needs**

***A social history of the development of the  
Christchurch Early Intervention Programme  
(The Champion Centre)***

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**This narrative is based on four life story interviews conducted  
with  
Dr Patricia Champion  
Founder and Director of the Champion Centre**

**These interviews were conducted by Rosemary Du Plessis who also  
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## Prologue

This account of the Early Intervention Programme is based on interviews with Patricia Champion, the founder of the Early Intervention Centre, now called the Champion Centre. The focus for the interviews was how the Centre became established, the recruitment of staff, the expansion of the range of children and parents using the services of the centre, and the constant challenge to find a physical location for the services established to meet the needs of babies and young children with actual or potential learning disabilities. All the quotations in this narrative are extracts from the transcripts of four life story interviews conducted at Patricia Champion's home in Christchurch over several months in 2000.

The narrative is organised chronologically and addresses some core themes. These themes include: the process of establishing an innovative intervention for children with Down's Syndrome; issues of mainstreaming in early childhood and primary education; parent/child/professional relationships; finding a 'home' for the centre; resources, policy and politics; and the development of administrative structures for the centre. This story highlights the significance of formal and informal social networks in the establishment of an intervention that has largely operated outside the mainstream institutions directed at meeting the needs of children with actual or potential special learning requirements. It also illustrates the extent to which innovation depends on the unpaid or underpaid work of individuals with vision, persistence and commitment.

Patricia Champion's doctoral research provided the impetus for the establishment of the multidisciplinary intervention that is now called the Champion Centre. This research involved a programme of interventions with children diagnosed with Down's syndrome and their parents/caregivers. It developed into a programme for preschoolers with actual or predicted learning or developmental disabilities that has been running continuously since 1979. At the core of this programme was intensive work with the parents of these children - work that was informed by an ecological orientation to education and child development. This approach entailed seeing each child as a node in a network of social relations, relations that most crucially involved their parents and other family members. According to this model, any successful action by professionals directed at enhancing the lives of children, especially children with special needs, entails working closely with parents and/or those who are involved in caring for children on a day-to-day basis.

Patricia Champion developed a specific programme of clinical interventions for children with Down's Syndrome that was to be implemented by parents who worked with professionals to achieve certain goals with their children. This was trialed over a two year period and written up as a doctoral thesis in 1981. After the two-year trial, Patricia was challenged by Dr Terry Casely, a Christchurch paediatrician, to continue the programme.

Over the last twenty years a small group of speech therapists, physiotherapists, counsellors, early childhood education specialists and psychologists involved in this programme have had an effect on large numbers of other professionals, parents and children. In the early days of its operation the programme was marginalised and received little attention. According to Patricia Champion, 'It was not seen as the route for the

future. They were not looking at what the literature was saying or what human rights were all about, or even changes in medical science that meant that people with Down's Syndrome were living so much longer.' Now the centre is an integral component of services available in Christchurch for children with special learning needs.

To understand how Patricia Champion came to develop this programme it is necessary to consider the context within which she developed the ideas and the experimental orientation that contributed to the establishment of the Champion Centre. This work was inspired by her teacher and mentor Dr Jean Seabrook who provided a model of a practitioner who was committed to innovative cross-disciplinary practice consistent with cutting edge research. It was also informed by the educational theory and child development research that she encountered during her studies of education and psychology at the University of Canterbury.

The opening section of this narrative explores some of these influences on the interventions pioneered in Patricia Champion's doctoral research, research that laid the foundation for what is now called the Champion Centre. It also indicates the key stages in the development of Dr Champion's career in this field and the challenges involved in combining parenting, study and part-time university teaching in the late 1970s and early 1980s.

This is followed by a discussion of how the work of the centre continued beyond the period of thesis research, how it operated under the umbrella of the IHC, and the factors that led to the formation of an independent charitable trust to support the programme. This narrative documents the movement of the centre between several different venues and highlights the work of some of the key actors in the establishment of this strategy for advancing the learning of children and working with parents.

The narrative concludes with attention to future directions for the centre, particularly the challenges associated with finding a new director for the programme and recruiting full-time clinical staff. The final section of the story explores issues relating to the relevance of the Treaty of Waitangi and kaupapa Maori for the work of the centre and reflects on the factors that have contributed to its development over the last twenty-two years.

### **Setting the context: developing a basket of knowledge**

A crucial influence on Patricia during the years she trained as a speech and language therapist in Christchurch in the 1960s was Dr Jean Seabrook who taught the Speech Therapy programme at the Christchurch College of Education. Dr Seabrook was not just a committed teacher, but also interested in research and writing. She combined speech therapy with attention to psychodynamics and adopted an interdisciplinary approach to speech therapy. She was to have a major impact on the way in which Patricia Champion was to approach her own work as a professional speech therapist. According to Patricia:

Dr Seabrook was full on, a workaholic. She was enormously demanding ... she questioned everything (and) ... looked at how things came together and how what seems may not be. And it was the beginning of being trained to think analytically... Although we didn't understand it at the time, she was really using a psycho-biological model of development before anybody else used that term. And then she was charismatic in terms of her personality.

Dr Seabrook had a very different approach to speech therapy and a very different professional style to practitioners in the field at that time. She had a degree in English and a PhD in Psychology. She was a trained speech therapist and also a trained child psychotherapist. She modeled the multi-disciplinary approach to working with children that would become central to the programme Patricia was later to initiate.

While completing her Diploma in Speech Therapy, Patricia also took courses at University of Canterbury, majoring in English and Education a year after she completed her diploma. This study was combined with work as a speech therapist at the Christchurch Normal School. After completing her degree, Patricia was invited to teach in the Speech Therapy programme with her mentor Jean Seabrook. But she also applied for and received a University Grants Committee Scholarship to study for a master's degree in Speech Pathology at University of Hawaii. After the scholarship was granted, she discovered that the Speech Therapy course she had done was not equivalent to the degree at University of Hawaii, and she would have to do some prerequisite undergraduate courses there before enrolling in the master's course. She was concerned about whether the scholarship would be enough to cover this additional coursework and decided that she would not go to Hawaii. While the opportunity for study outside New Zealand was there, it seemed, at the time, fraught with difficulties.

While she did not pursue study abroad, she did engage in clinical work alongside Dr Seabrook. Through this relationship Patricia Champion developed her clinical skills and was exposed on a day-by-day basis to someone who was interested in 'pushing the boundaries' and constantly thinking about the relationship between research and practice. She also began a two-year master's degree in Education specialising in Child Development.

Within the field of Child Development, Patricia became interested in how the relationship between mothers and children developed through infant feeding. This was an opportunity to combine attention to Freudian and Piagetian theory with a focus on things important to the development of speech like sucking and swallowing. Her master's thesis research

involved following a sample of women who were having their first babies through pregnancy and the post natal period. During this period she got married, continued teaching speech therapy and was engaged in clinical practice.

Patricia was also invited by Professor Lawrence to teach the third year Child Development course at University of Canterbury, as he was going on leave. Dr Graham Nuthall also asked her to teach in the Tests and Measurements course that involved teaching about educational research. For some years Patricia was a junior lecturer in the Department of Education and took tutorials in Child Development. After finishing her thesis, she went off by herself and travelled in Europe for three months. According to Patricia, 'This was very frowned upon... It was not consistent with the work ethic to go off like that for three months and married women were not expected to travel by themselves.' Within a year of her return, her first daughter, Felicity was born. She continued part-time teaching at university, and in 1979, after encouragement from a visiting woman academic; she decided to do a PhD. It was this PhD research that led directly to the development of the Early Intervention Programme. Patricia was interested in exploring how learning occurred in the context of mother/child relationships when children were diagnosed with Down's Syndrome. This related both to her master's research topic and her long term interest in child development, especially speech and language.

Dr Terry Casely, one of two Christchurch paediatricians, was the key to finding children and parents who might participate in this research. He had been present at the birth of both of her children and was also 'a name in the speech therapy world'. She went to see him, talked about the aims of her research, and he agreed to provide the names of parents he had seen whose children had been diagnosed with Down's Syndrome. He also agreed to act as her sponsor at the hospital. This collaborative relationship between Dr Casely and Patricia Champion has continued for over 20 years and is a core ingredient of the success of the Early Intervention Programme and its survival at various moments in its recent history. Dr Casely has continued to be a significant advocate for this work among others in the medical profession.

### **Pushing the boundaries: early intervention for children with Down's Syndrome**

In the 1970s children born in Christchurch with Down's Syndrome were usually admitted to Templeton Hospital between three and five years of age. This was preceded by a few years at home with their parents or in special care homes in which they were cared for as babies. Some people still thought that it was better for these children to be institutionalised. They were taught in special schools and generally excluded from mainstream education. Patricia commented that:

It was as if they were on a different planet really. Once you had given birth to a baby that was not normal, it was not to be valued or imbued with characteristics that were humanising. They were seen as something less than human.

The aim of the research was to establish a relationship with the caregivers of all children born in Christchurch with Down's Syndrome over two years and invite them to participate in a learning programme for the children. Most of these caregivers were the children's

biological parents, but a few were foster parents who later adopted the children in their care. Fourteen children and their parents/foster parents were part of this original group of parents and children - the foundation families of what was to become the Champion Centre.

In order to assess the effect of this intervention it was important to try to establish a control group, a group of children who were also diagnosed with Down's Syndrome, who were not involved in the therapeutic programme Patricia Champion had developed in Christchurch. A control group was eventually established in Dunedin with the help of Dr Anne Smith, a lecturer in Psychology at Otago University and with the assistance of a paediatrician who Patricia knew from her time at University at Canterbury.

Children with Down's Syndrome who were born in Dunedin were less likely to be institutionalised because there was no big facility like Templeton Hospital. Children with Down's Syndrome were more likely to be cared for by their parents or in foster or small special homes in Dunedin. During the first two years the programme was running in Christchurch, Patricia would go down regularly to Dunedin to compare the development of the children in the control group with the children in Christchurch who were involved in the project. Once again personal contacts with someone in the medical profession were crucial to getting the research project off the ground. 'If it hadn't been for the personal connection, it would have been almost impossible.'

All the Down's Syndrome children born in Christchurch during 1979 and 1980 were brought by their parents or caregivers to the Fendalton Plunket Rooms once a week to work with Patricia and a physiotherapist. 'She did the physio and I did language and the feeding and the cognitive stuff... We did it together.' This was the beginning of the commitment to the integrated, but multidisciplinary response to work with children with special needs that has characterised the approach of the Christchurch Early Intervention Programme. Parents and caregivers were encouraged to use these interventions with their children on a regular basis at home. 'The idea was, using Bronfenbrenner's model, that the context in which they lived their own lives was the crucial factor.' The programme was a resource that encouraged caregivers to do different things at home. Mothers would bring other members of the family into the Plunket rooms, 'so, the influence went in several directions.'

At the time Patricia Champion started running a programme, her eldest daughter, Felicity, was starting school and she had a new baby, Louisa. Sometimes Patricia would put the baby in the pram, and by the time she arrived at the Plunket rooms Louisa had gone to sleep. 'And with a bit of luck she would stay asleep. I'd put the pram out the side, round the corner, so totally out of the way.' She found little support at the university or in the community for this attempt to combine research and parenting. She didn't have any family to help her, but did find a wonderful trained nurse to care for her daughters a couple of afternoons a week who she could trust completely. This caregiver was very supportive of Patricia's work and the children formed a very close and special relationship with her.

### **From research to an ongoing centre for early intervention**



Patricia completed the research for her PhD in 1981 and submitted the thesis in 1982. Most of it was hand written late at night and typed up by someone else. Friends helped with the proof reading. According to Patricia: 'It was a sort of combined effort, everybody did their bit.' She submitted it and then it 'disappeared into the woodwork.' It was almost a year later that she was finally awarded the degree. By that time the programme had grown and Patricia was focused on practising early intervention rather than academic writing. Patricia remembers Graham Nuthall saying: 'You really must write something', but she did not really want to write academic papers. The thesis had been 'the next thing that needed to be done' and, once it was completed, the programme was of most interest, not writing about it. 'I didn't really have a burning desire to write a thesis or have a PhD or something. I think it is a bit amazing that it actually happened.' In the mid 1980s Patricia produced a summary report based on the thesis that is still used as an example of action research using an ecological model.

As Patricia was completing her thesis in 1981, Terry Casely stated that, 'We have an ethical responsibility to do something more for these families.' The children in the programme were doing much better than the literature suggested was possible for children with Down's Syndrome. There were also new children being born who were candidates for the programme. 'So we just had to do something for these babies; we just had to carry on, so I did.'

Terry Casely decided to explore the possibility of locating the programme in a department within the medical school and he approached the Departments of Pediatrics and Psychiatry to see whether the Early Intervention Programme Patricia had developed could be included in the system of child mental health associated with the University of Otago Christchurch Medical School. According to Patricia: 'A lot of disability was under mental health in those days. And paediatrics was, of course, organised around treating the biological needs of these children.' It appears that the Professor of Paediatrics and the Professor of Psychiatry could not agree about the location of the Early Intervention Programme, so Dr Casely, who was the local president of the IHC at the time, approached the local branch of the IHC and asked them whether they 'could take this under their umbrella. We left the hospital behind and moved to the IHC.'

The strategy Patricia had developed was very different to the approach of the IHC, but the manager at the time, Roger Foley, was prepared to 'take on board a different way of doing things'. At that time once children with Down's Syndrome were three, they would get in a taxi to the IHC preschool where they worked with professional carers and then were returned to their parents later in the day. The approach that Patricia had developed was very different because it involved developing a close relationship between the clinical professionals interacting with the children and the parents. Roger Foley was open to arguments about the need to pay attention to the context in which children with disabilities were cared for, and, as a result, the Early Intervention Programme was able to 'do their own thing' under the umbrella of the IHC. Once the relationship with the IHC was established, the staff in the Early Intervention Programme began to receive \$6.00 an hour as payment for the work they were doing with the children.

Terry Casely was the key link between Patricia Champion and the IHC at this time. The children who were involved in her programme were potential clients of the IHC, so its support for her service was support for a competing service provider who was adopting a different approach to improving learning outcomes for children with learning difficulties or delayed learning. Dr Casely was very supportive of the Early Intervention Programme and referred to Patricia all the children he had contact with that were diagnosed with Down's Syndrome. The other paediatrician was less supportive, but Dr Casely was seen as 'the disability man', so most parents of children with Down's Syndrome would soon be advised to see him. Dr Casely considered that the programme did not just improve the learning outcomes for the children; the attitude and vision of the parents in this programme was very different. Since Christchurch is a small place, parents using the programme were in touch with other parents with Down's Syndrome children, they spoke about their experiences and those children would end up seeing Dr Casely and becoming involved in the Early Intervention Programme.

Parents would bring their children to the Fendalton Plunket rooms one morning a week and work with Patricia and the physiotherapist. They would also meet other parents. Most of the parents or caregivers who brought their children were mothers. There were two foster families involved in the early years of the programme. One was an older couple who already had a child of their own with a disability. Another child was fostered by a single woman who was an IHC caregiver. She already had a little girl who she fostered and then she became the foster parent for a baby from a Maori family. The child's mother left the baby behind when she went back to whanau in the North Island. The Karitane Hospital cared for the baby for a while and then she was adopted by this single parent. This was unusual at the time for a single woman to adopt a Down's Syndrome child.

### **Organisational, professional and personal networks: growing the programme**

In the third year of the programme there was another significant development that brought a new set of people into the programme. Patricia Champion was invited to talk to a Special Education Course run at the Christchurch College of Education by Peter Hallanan. He had been the parent of a child with Down's Syndrome who had died when she was two. One of the people in that class spoke to Patricia at the end of her presentation about becoming involved in the work with the children. Two others in this class also asked whether they could help, and all three eventually came to the Fendalton Plunket rooms and did developmental work with the children.

At the end of that year two of them went back to the North Island to work, but Jenny Gibbons stayed on in Christchurch and was due to go into a job at the Ferndale Special School. 'She was captivated by what we were doing ... and worried about going into a special school.' With the support of Barry Nelson, the head of the Special Education inspectorate, she managed to negotiate that she could work in the Early Intervention Programme one morning a week. She was able to convince Barry Nelson that the work she was doing there was important. And at the end of two years she became a full-time worker for the IHC. This involved working for the Early Intervention Programme, because they were under the umbrella of the IHC. Jenny Gibbons' work included

developing a home visiting programme for the IHC for parents with children under three. So she began to work with children in their own homes using the principles of the Early Intervention Programme.

Jenny Gibbons remained closely associated with the programme. At certain times she worked full-time, at others part-time while she had young children. Patricia indicated that: 'She still keeps her hand in by doing assessments and supervises new staff. Her involvement spans twenty years.'

Someone else who made a key contribution to the programme at this time was Jan Murphy. She had been trained by Patricia when she was a speech therapy student and was one of her outstanding students. Patricia met her at a time when she was under increasing pressure to meet the needs of the parents and children who were coming into the programme. Jan, who had a young baby at the time, joined to programme to assist with the speech therapy work and has been there ever since. According to Patricia: 'She would now be the person with the greatest knowledge of the whole programme and the most senior and respected person.'

While the work that Patricia and others were engaged in was now under the umbrella of the IHC, there remained significant differences in the underlying philosophy of the two programmes. According to Patricia: 'They (the IHC) didn't operate according to the literature, they operated according to what the person before them had done and just kept on providing care for life.' However, IHC was one of the key organisations in the field of support for those with disabilities and recruited some staff who were interested in new strategies of clinical practice. They recruited as a social worker a former Catholic priest, Mike Gorman, who was very supportive of the programme Patricia had developed. Patricia considered that overall the workers for the IHC did not tend to read new literature in the field; support for different approaches came from 'a social justice ethical standpoint more than from an academic viewpoint.'

Another key source of professional support was Barry Nelson, inspector for Special Education. His whole working life was organised around support for those with disabilities. He also had a keen appreciation of the social justice issues related to disability services. According to Patricia, disability politics in Christchurch was significantly influenced by individuals who were key players in the arenas like the Teachers' College, the University of Canterbury and the Department of Education.

Dr Jean Seabrook remained a key mentor for Patricia during this time. She had retired from Speech Therapy Training, but had a new career in the field of specific learning disabilities. Patricia would go to talk to her about the work she was doing. She also spoke to Dr Bill Watkins who was a child psychiatrist at the Child and Family Service about the clinical practice in the Early Intervention Programme. He had just come back from Canada and had young children himself. His wife, Helen, became involved in the Fendalton Playcentre, and, through that connection, came to work in the preschool area with children in the Early Intervention Programme. Her first training had been as a physiotherapist, and when one of the physiotherapists in the programme was leaving, she

moved into that field of work and is now the senior physiotherapist at the Champion Centre.

The extent to which personal networks were important in the establishment of the centre is illustrated by the case of a friend of Patricia's who was having a frustrating time at home with young children and who offered to help with the programme. She took on responsibility for making the tea for the parents while they were at the centre with their children. This was a very important part of the programme, a time when parents had a chance to talk to one another. It was also important for breast feeding mothers who needed to 'top up' their fluids.

This friend started as tea maker, then moved on to do other things like cleaning up and making play and educational equipment. She also collected families and brought them to the centre. When Patricia returned from a trip overseas impressed by the work being done using computer technologies with multi-disabled children, this friend and supporter of the centre purchased her own computer and expanded her expertise in this field. According to Patricia:

She finally got her head around it and now she solely does that for the programme. She would be the expert on computer assisted learning for children with multiple disabilities now. We started it when no one else was doing it. She initiated it and it has taken off.

This is just one example of how the programme in its early days depended on informal linkages and multiple contributions from individuals, some in a professional capacity and some in a volunteer capacity. According to Patricia: 'It was a very supportive small community of women who helped one another make it possible.'

A number of the physiotherapists who have worked in the programme were married to doctors and these connections have been very important in raising the profile of the Champion Centre among the medical profession in Christchurch. Through their husbands, women involved in professional work at the centre have raised the credibility of the centre and contributed to its standing among doctors. Pathways to key actors in the medical profession have been 'smoothed' by these informal linkages.

Some of the other women who came to work in the programme had connections to women friends who were having children. They were supportive of what their friends were doing, and so the culture around children and intellectual disability began to change. When women who worked in the programme had to leave their jobs, they headhunted among those they knew for a colleague to replace them. Patricia said that: 'We didn't need to advertise, we do now, but we didn't then.' People who worked for the programme were very committed to it and they wanted to ensure that someone they could trust would take over from them. They thought: 'Would their personality match this way of working? What about their qualifications?'

Connections between parents of children with Down's Syndrome were a very important part of the Early Intervention Programme. According to Patricia:

It was a matter of balancing the very different living environments of the children and families who came together. And we wanted to facilitate connections between those families. Living their lives very differently, but coming to common places around a common need to be there. And supporting one another. There was a family with nine children with very experienced parents and a seventeen year old mother of a new born child.

Six children and their parents were involved in each session so there were significant opportunities for parents to interact with others while their children were at the centre for the morning.

All the parents were very motivated to do good things for their children. They came from all over Christchurch and even further afield, like Ashburton and North Canterbury. Once a family was in the programme, every effort was made to assist them and sustain their involvement. Sometimes that involved visits to the home if a child was fragile or ill. But there were also volunteers who would pick up families and bring them to the Fendalton Plunket rooms if they needed assistance with transport. The Young Wives group at Patricia's local Anglican church were approached to take on assistance with transport as a community project. According to Patricia: 'For years these women ran a roster and picked up families and brought them to the centre once a week.'

### **From the Plunket rooms to the Playcentre: access to mainstream preschool education**

The children who had been part of the original doctoral study were now three years old and ready to become involved in early childhood education. Normally they would have gone to the IHC preschool, but Patricia was interested in their access to mainstream kindergarten or playcentre education. She spoke to Dr Anne Smith, who was one of her thesis supervisors and increasingly a leading figure in early childhood education, about the need to facilitate these children's access to mainstream preschool education. Following these discussions, Christine Reitveld, who had completed her BA degree with Anne at Otago University, was employed by the IHC to facilitate the project of integrating children in the Early Intervention Programme into mainstream preschool education. Christine was to develop a strong connection to the Department of Education at the University of Canterbury and was associated with the Early Intervention Programme for the next fifteen years.

For Patricia it was very important that the new literature on child development should be applied to thinking about appropriate interventions for children with disabilities. There was a tendency for the disabilities literature to be marginalised. Her argument was that 'we needed to think "child first, disability second".' She sees Professor Graham Nuthall as very important in supporting this philosophy. The model of 'the expert' was being challenged and the focus was on the interaction between child, parents/caregivers, professionals and the environments in which the children were located. Patricia considered that 'another creative pathway had to be found to establish connections with the preschools. It was difficult for the parents and for us and the preschools, and it was not always that successful.'

Christine Reitveld would talk to the parents about preschool options for their child and then go along with them when they went to enroll their children in some form of preschool education. Sometimes this was very difficult. According to Patricia, 'It really was hard, basically they didn't want the children.' Sometimes the children were there 'under sufferance'.

In playcentres the parents were encouraged to be there with their children and this was more consistent with the model of parent/child/professional relationships that had informed the work of the Early Intervention Programme. But at kindergartens, according to Patricia:

It was an expert model. Some of the staff had a tragedy view of disability and their own prejudices were very evident in those days. And this was very marginalising. For parents fronting up to preschool with a three and a half year old child or a four year old it was a huge reawakening of their grief in the difference between their children and the ones who were at preschool.

In the IHC preschools teachers had the highest expectations of children with Down's Syndrome, but in the mainstream preschools they were the children whose teachers had low aspirations. According to Patricia: 'We were straddling yet another coal face... And it took years...' The staff at the centre had to remain very focused on the way in which 'child development is a process'. They also had to hold on to the commitment to each child achieving their potential. Now attitudes to mainstreaming have changed, but then it was a struggle.

A few of the children who had come through the programme did go to the IHC preschools. Sometimes parents were persuaded by GPs and other family members that these preschools were the best option for their children. The children who ended up going to the IHC preschools were generally the children with the most severe health problems, such as heart conditions that could not be repaired. The children with the frailest health had most difficulties learning in the programme. They also sometimes had behavioural difficulties. Four of the children involved in the initial Christchurch study died as a consequence of congenital heart difficulties, as did four of the children in the Dunedin control group. Heart problems were a key source of illness for these children. These problems are now more effectively treated than they were in the early 1980s.

One of the preschool centres that was drawn into the programme of mainstreaming children with Down's Syndrome in the early 1980s was the Fendalton Playcentre. A number of the parents using the Early Intervention Programme lived in the area and it was their local preschool centre. It was also very close to the Fendalton Plunket Rooms where the programme was initially conducted.

The supervisor at the playcentre at the time was Marjorie Abrahamson, who had done a master's degree in Child Development the year before Patricia had done her Master's degree. She had also been a primary teacher. When her children were young she did playcentre training, and eventually became a playcentre supervisor. Because she was someone Patricia knew, and because she also had a strong social justice perspective and a commitment to children, she started to take children who had come through Patricia's programme. According to Patricia: 'A lot of children actually went there because of her.'

By that time, Marjorie Abrahamson was a senior and respected person in the playcentre movement. She had some influence with other supervisors in Christchurch. There were, however, some inconsistencies between the pedagogical philosophy of the playcentre movement and the Early Intervention Programme. Their orientation was: 'We don't interfere in children's learning' whereas Patricia's programme was organised around a series of interventions. The Early Intervention Programme was based on the perspective that you had to facilitate learning, otherwise it would not happen. Eventually Marjorie Abrahamson came to work for the Early Intervention Programme, first of all working with Christine Reitveld to facilitate children's access to mainstream preschool education, and then working in the clinical programme. She now works in the strand that focuses on developmental therapy. Through her connection with the playcentre movement, many people have come to work in the Champion Centre programme.

Forging connections with kindergartens and kindergarten teachers was more problematic. Kindergarten teachers tended to see themselves as expert early childhood educators and they wanted the children who entered their programme to do exactly what the other children in their programme had to do. That was not always appropriate for children with Down's Syndrome who were going into a kindergarten environment. One of the children was expelled from a kindergarten. They then went to a playcentre and 'there was no trouble at all.'

### **Expanding the programme**

In the third or fourth year of the programme Terry Casely suggested to Patricia that she include a child who was not diagnosed with Down's Syndrome, but did have an intellectual disability. He asked her to see this child and see how they responded to the programme. 'We did see the child and worked with the child according to the same principles and it was very effective. Then he kept on asking us to see another child and then another child.' In this way, the children in the programme began to include children with cerebral palsy and other disabilities.

Again personal networks were important in the development of work with children with cerebral palsy. Someone who had worked with Patricia earlier and left to focus on parenting her first child was a specialist in work with children with cerebral palsy. She had worked full-time at the school for children with cerebral palsy and came to work in the Early Intervention Programme as a specialist on interventions for children with cerebral palsy. She, together with the physiotherapist who began the original work with Patricia at the Fendalton Plunket rooms, Jenny Gibbons, Jan Murphy, Helen Watkins, Marjorie Abrahamson and Christine Reitveld were the key people whose work had an impact on the development of the programme.

By the mid 1980s the programme included children with cerebral palsy and other disabilities, as well as children with Down's Syndrome, and encompassed children from birth to six years. It involved a programme that integrated children into mainstream preschools and one that involved visits to families in their own homes. It was funded

through the IHC, but had a different overall philosophy to the IHC, particularly with its focus on adopting professional practices informed by the latest child development literature and its commitment to working with parents and diminishing the power of 'the expert'. The children who were in the original early intervention group were now reaching school age and the Early Intervention Programme became involved in the process of integrating them into mainstream primary schools. This involved work with their teachers and other children in the schools. A lot of work went into ensuring that there were also services in place in the school environment for children who were starting school.

Sometimes children from the Early Intervention Programme settled very well into their school environments, sometimes there were problems. According to Patricia: 'It had less to do with the child and more to do with the culture of the school and with the expertise of the staff. Sometimes staff would get stuck and they didn't know how to unstick themselves and they didn't know how to ask either.' The Department of Education was not well resourced to respond to children with special needs and they did not have a lot of experience with Down's Syndrome children, since previously most of them had been at special schools. 'They didn't know a lot about how to get them learning.'

An expansion in the number of children using the programme meant that there was a need for more space. The programme was first offered at the Plunket rooms and then at the IHC preschool rooms in Avonside for a couple of years. Then space also became available at the Teachers' College. Soon this space was also insufficient and the St Barnabus church hall was used in conjunction with the space at Teachers' College. Each time they moved they outgrew the space they were allocated and then depended very much on interpersonal relationships with individuals who controlled access to alternative space. A good relationship with Jack Mann, the principal of the Teachers' College, facilitated access to space at the college. When he retired the next principal was not so positive about accommodating the programme. Patricia Champion was a parishioner at St Barnabus and this was the basis for negotiating access to space in the church hall for which they were not charged. The babies used the hall and the older children were at Teachers' College.

While they were located at the Teachers' College, people with professional interests in this field would drop in to observe the work going on at the centre. These observers included students doing early childhood education and lecturers at the college. This was important for establishing the legitimacy of the programme and extended knowledge about it among those working in the early childhood, child development and disabilities fields.

The payment of \$6.00 an hour for staff began when the programme came under the umbrella of the IHC and 'continued for years'. This was their standard wage. Most of the professionals working in the programme were part-time. They were often parents of young children and wanted flexible employment. They could only do this work because they were usually in a family where there was another adult who was the major earner. An exception was Pauline Reitveld who was employed by the IHC on a professional salary. Most of the equipment was also purchased by those working in the programme. At this



time Patricia started to visit similar interventions in Australia, Hong Kong, America and the United Kingdom. These visits were self-subsidised and fed back into the work of the centre.

The parents who had used the programme were beginning to see that opportunities for their children were not just 'pie in the sky'. They had started to expect that 'their children would have a more normal life.' These parents expected to get satisfaction out of seeing their children move through different developmental stages. It might take them a bit longer, but they could achieve certain goals and experience milestones in their development.

### **Becoming independent: the establishment of the Early Intervention Trust**

By the end of the 1980s, Special Education Services had developed within the Education Department and they had a Special Education Advisor. The Early Intervention Programme had now become a dominant force in disability service provision in Christchurch. The Special Education Advisor had, as part of her brief, liaison between the programme and the early education providers and schools. But the person in this position had a very 'Special Ed' orientation to this work. She and Christine Reitveld had very different approaches to this work and they did not get on well.

By the end of 1988 the differences in philosophy and overall approach of the IHC and the Early Intervention Programme were becoming even more apparent than they were in the early 1980s when the centre first came under the umbrella of the IHC. The Early Intervention Programme had grown quite rapidly and applied to the IHC for someone to look after the administrative aspects of the programme. The IHC initially indicated that the centre could decide on whom they wanted to employ, but in the end they appointed someone without consulting with the center. This person left the job after only a month. It appeared that the IHC wanted to use this administrative position to shape the work of the centre. 'The person they wanted came with a very different model of disability. They didn't match with the way we were going.' Patricia considered that what they had been doing was successful and supported by the literature. Those in senior positions within the IHC had different ideas 'and so there was a huge falling out ... with the IHC.' This was not just a matter of differences in clinical approach. The centre used a cooperative decision making structure and this did not fit the hierarchical model of decision making within the IHC.

At that time, the husband of one of the staff members, Dr Neil Cherry, decided to 'take the IHC on'. A meeting was held at the St Barnabus Church Hall and the parents were asked whether they wanted to stay within the framework of the IHC or to become totally independent. The parents decided that they wanted to be independent of the IHC. Soon after this Patricia Champion was away in Dublin for a meeting. When she got back a charitable trust had been set up to support the centre. From 1989 onwards, the Early Intervention Programme was not just professionally autonomous, but financially independent.

Parents, teachers and other relevant professionals, like Dr Terry Casely, were represented on the trust that was set up following the split from IHC. This trust appointed a family counsellor, Kay Berry, to work with all the parents involved in the programme. She remained with the centre for a long time before moving to Sydney. This was a frequent pattern for staff; most were employed for many years. They usually left when they had young children, but, when their family circumstances changed, they came back to work in the centre. According to Patricia: 'The staff has been the service really... It was their belief that they wanted to work in this way and they wanted to make a difference for children.'

At the time of the split with IHC, about a dozen people were working at the centre on a part-time basis. They were not well paid, but they did appreciate their professional autonomy. They wanted to preserve this independence and were prepared to take the risk of operating outside the financial and organisational of the IHC. The trust negotiated payment for staff from a variety of different sources and engaged in fundraising. Some years later in 1992, the commitment of all the staff was highlighted when they continued to work without salaries for six months when funding for their work shifted from Social Welfare to Health and Education. According to Patricia, the officials said: 'You are entitled to the money, but the government hasn't told us what to do about you. So you are not in the system, even if you are entitled to support.'

Neil Cherry continued to be very active politically on behalf of the centre, but when the government changed at the end of 1990; he lost of some the key connections that had been important in the late 1980s. However, his support and activism at the time were crucial to the survival of the centre. He was 'an issues man' who 'knew how things worked'.

### **Finding a new location: the shift to Glenmoor School**

The programme was again outgrowing the space available and needed to find a new, more long-term home. A supportive psychologist in the Special Education Service found a spare classroom at Glenmoor School that was suitable for the work of the centre. The school was in the country and was too big for the present number of students and the dental service had been discontinued. 'So we took over a classroom and toilet facilities and the dental clinic'. The centre was to operate from Glenmoor School at the end of Philpotts Road for the next six years. At this stage in the development of the centre Jennifer joined the centre to work in the office. She had worked for the IHC in Ashburton and moved to Christchurch to be near her family. She was still working in the office in 2000 - more than ten years later!

At Glenmoor School the centre occupied a classroom and the dental clinic. Next to them was the local playcentre. There were close connections between the two programmes and some of the children at the Early Intervention Programme attended the playcentre - 'all they had to do was go next door.' The headmaster was very supportive. Some of the children in the programme went from there to playcentre and then on to the school. Babies, preschoolers and school aged children were all in the same environment - 'it was an ideal situation to practice inclusivity.' One of the playcentre supervisors, Jackie Grant,

eventually came to work at the Early Intervention Programme. She came to work in the preschool with the children and now is the co-coordinator of that aspect of the programme.

### **Another home: the move to Ward 4 at Burwood Hospital**

After some years the centre started to outgrow the dental nurse's office and the one classroom that had been allocated to it at Glenmoor School. First a prefabricated building was added to the dental clinic and that provided a big clinic room. Eventually the centre outgrew this space as well, and Glenmoor School also expanded and needed its classroom back. The prefab building was sold to Paparoa Street School where several of the children in the programme had started school. A key actor in this was one of the parents who was on both the Early Intervention Trust and the board of Paparoa School.

Patricia Champion spent a lot of time searching for another location for the centre and eventually was offered some space at Burwood Hospital. The Child and Family Patient unit was relocating to Princess Margaret Hospital and their premises seemed the most suitable. The staff looked at the space with an architect who provided advice on how it could be converted for use by the children. A lease was signed and all the other documentation was done when, just before Christmas, the manager phoned up and indicated that the people working there were refusing to move. 'We could have held them to the lease, but we didn't.' Patricia remembers sitting in the manager's office and thinking: 'It is almost Christmas and we have to find somewhere to go for next year'. What had been so carefully planned was falling over. The manager then said: 'Well, there's only Ward 4, but you won't want to look at that... It is terrible, it had a fire in it and we haven't used it in five years'. Patricia went to see the derelict ward. 'It was full of dead beds, and commodes and theatre trolleys with wheel chairs just heaped around.'

She went away 'quite despairing' and rang up some staff to get them to come and look at the space. They did this with some of the children 'in tow' and they looked at it, sat down and talked and said, 'It will be fine, we will make it work'. Parents needed to be consulted as well. 'We needed to talk to them about how it would feel to be in a hospital.' According to Patricia they would never have considered a hospital an ideal place for the centre. The other building was not part of the hospital, although it was in the grounds. The original building they had been offered had its own entrance, but Ward 4 was very much part of the hospital environment; it was also upstairs and serviced by an old lift. The parents said, 'Wherever you guys are is fine by us. It is you guys we want, we don't care about the place'. The service was more important than the place.

Then the space started to be transformed. 'And suddenly it all happened and on the smell of an oily rag we made it absolutely beautiful.' Staff found \$10 chairs at a second hand shop as well as curtains. Paint was purchased on sale and the walls transformed. A bright, colourful environment was created and Ward 4 became the 'home' of the Champion Centre for the next six years. The staff and parents enjoyed access to the cafeteria and the staff could activate the cardiac arrest button in the hall if any baby did experience such arrest. It seemed like a safe environment.

The move to Burwood coincided with Professor Alan Clarke becoming Clinical Director at Burwood Hospital. He had a philosophy of habilitation rather than rehabilitation and 'was enormously supportive and encouraging of us being there.' The Champion Centre programme was very compatible with his vision for community-focused interventions. When international visitors come to Burwood he would bring them to visit the centre and refer to it as 'my magical place'. Like the time at Glenmoor School, this was an environment in which the centre was appreciated and welcomed.

### **Micropremmies, other children with learning disabilities and their parents**

During the last few years at Glenmoor School and the first few years at Burwood Hospital there was a further expansion in the range of children and their families who were using the centre. In the 1990s staff at the centre became increasingly interested in the field of prematurity and the largest group of children in the service is now those who have been born prematurely. In the mid 1980s the centre started to provide a service for children with cerebral palsy and children with global developmental problems arising out of birth asphyxia or epilepsy. There are now also children in the programme with autistic spectrum disorder, an area where a whole range of expertise has been developed. Another group of children within the programme have developmental dysphasia, a very specific learning difficulty. The staff has begun to develop expertise in very specific areas, including the field of children with multiple disabilities. As more and more children with different areas of learning difficulty entered the programme, teams were developed with specific areas of expertise - strands within the programme that connected, but were also distinct.

Patricia has indicated that the strategy has been 'to go from the needs of the children who present themselves and then we have asked: 'what do they need to learn?' And then we have tried to get the resources around those children.' Children tend to be referred to the programme by doctors or by other parents. According to Patricia, 'This is a very small city and people get to hear about it through other people who use the service.'

In the 1990s children began to be referred to the programme at an earlier age. This was a consequence of greater awareness and better diagnostic work on the part of general practitioners and paediatricians. The greater survival rates of premature babies also contributed to the increased number of premature babies in the programme. Doctors were reading the literature and becoming aware of the possibility that these premature babies experiencing a range of disabilities. According to Patricia, 'Younger doctors coming through started to push the older ones to do something about this.'

The premature babies who are part of the programme are referred to in the United States as 'micropremmies' - children born between 23 and 28 weeks. 'That is very tiny, and within that group of micropremmies, 85% will have a disability of some sort that will persist.' Patricia spoke about the difficulties of getting money for interventions directed at these children:

This has only happened very recently because disability money was ring fenced. Disability meant certain things, and if you have a tiny premature baby you can't tick boxes and say they have this and this wrong because not enough time has passed. But if you let time pass, then you will create the secondary disability. That is the real problem.

Currently the premature babies come in with their parents every week for up to a year. Their parents are also at risk with respect to attachment disorders and postnatal depression - things that could also interfere with their babies' learning. After the first year, if the child has a particular disability, such as cerebral palsy, they will be covered by the disability funding strand. Children who do not have any specific disabilities go into a strand that involves a monitoring and review process until they go to school. This is funded out of the personal health strand of funding, but the centre had to work hard to access that funding for this service. The transition to school programme is still being done by a team of people who specialise in transition. 'And they do it enormously carefully and brilliantly because they know what the fishhooks are.'

Children and their families are drawn from all over Christchurch. Parents and children also come over from the West Coast and from South Canterbury. People living in Geraldine, Wanaka, Wellington and the Chatham Islands have been involved in the programme. The programme still attempts to facilitate contact between parents as well as provide a learning programme for the children.

The micropremmie babies are initially visited in their own homes and, when they first visit the centre, they come in for separate visits. These babies are often easily distressed and disturbed and mothers can't attend well to their babies when there are distractions that occur when a number of babies are together in the same room. Once their relationship is well established, the parents and babies come in two at a time for a whole morning or a whole afternoon. Two come in the morning and two in the afternoon and four parents may meet and have a cup of tea and talk to one another between sessions. Often they will have got to know one another in the neonatal unit. If they stay in the programme for more than a year, they go into a group programme because the babies then are more open to tolerating having more adults and children around.

Most of those who bring children to the centre are mothers, but there are also paid caregivers like nannies, as well as some grandmothers who are involved in the children's care. Fathers sometimes come alone with their children or with mothers. Often they will come in to the centre in the middle of the day when they have a break from work to participate in the programme. Patricia recollected that:

Initially it was all women. Then there was a time when there was a lot of unemployment and then it was sometimes two parents regularly, mums and dads. Then we went into a period where it was quite often dads. We still have some dads who are the major caregivers. You may come in one day and there would be no fathers. You may be there on another day and there would be heaps of dads.

Deinstitutionalisation of those diagnosed with mental illness has also generated new clients for the centre. Some of them are parents with intellectual disabilities or schizophrenia whose children have special learning needs. Some of the parents of the micropremmie babies are also young mothers because teenage mothers are over

represented among those with premature births. The programme at the Champion Centre is not just focused on the child, but also the context in which they are located. According to Patricia:

There is no such thing as "just a child". There is only ever a baby and someone else. So you just cannot provide a programme that does not address who is caring for the child. It is certainly not the therapist, it is the caregiver and that caregiver needs to be resourced. In various family structures resourcing the parent involves a lot of support.

The amount that the centre is able to access for this sort of family support has been diminishing as priorities shift in the field of Child, Youth and Family Services.

Until very recently the centre charged parents for the services they received. They paid \$5.00 a week for the therapeutic services offered through the programme and \$5.00 for the preschool services. Parents using the centre were usually entitled to the handicapped children's allowance that was \$26.00 a week. This allowance could be used to meet the costs of these fees. In 2000 the centre was told that it could not charge fees and this meant a drop in income of approximately \$50,000.

### **From the margins to the mainstream: becoming a dominant actor in the field?**

While once this programme was relatively marginal, it is now a Christchurch institution. Parents and health professionals expect it to provide services for children and it has become the largest service of its type in New Zealand where children who are at risk of developing learning disabilities or who struggle with delayed learning are regularly seen by a multidisciplinary team of professionals. Children with more severe disabilities are likely to use the services of the Special Education Service.

Children are referred to the centre by doctors and paediatricians. Patricia indicated that there was a 'huge standoff between the medical and the educational model.... Educational people often don't see the need for a medical referral and the medical people often see no need to use the educational services. They are absolutely different.' The Early Intervention Programme is committed to communication across this divide. It differs in its approach from the Special Education Service (SES) which, according to Patricia, tends to focus on a play model and work through preschools with early intervention teachers who are trained in an education model rather than a psychobiological model. They are teachers rather than clinicians.

Children's access to various services is now assessed through a 'needs assessment' structure. Patricia defines this process as 'a gatekeeper for parent choice'. Parents whose children have been diagnosed with Down's Syndrome now have to go through this assessment process before they can access the services of the Champion Centre.

The centre has developed a set of very innovative practices for children with the autistic spectrum of disorders, but they are very time consuming because they demand one-on-one work with children. The practices have been developed, and the staff is there to work with the children, but there is a need to get the money from mental health services to finance

the programme. Patricia is hopeful that publicity about the stress experienced by parents with children with these disorders will encourage government to put more money into work in this field.

### **Administrative restructuring: from cooperative decision making to a management structure**

Until the mid 1990s the programme was run using a very cooperative decision making process. Decisions were made at regular staff meetings. As director of the centre, Patricia found herself 'running around trying to inform everybody about what was happening all the time. It got totally unwieldy.' She had stopped doing any clinical work because she could not do that and the other things needed to keep the centre going. She was paid for 25 hours a week, but the job was effectively a full-time position. It involved not only the development of the centre and attention to staff issues, but a significant amount of networking outside the centre to generate the resources for the programme and effect changes in other places in the interests of the children using the centre.

The centre, now called the Champion Centre after its founder, has been administered by a trust board since the late 1980s. In 1996 a senior management team was established. Patricia Champion is the director and there are three senior clinical managers who cover each of the main strands of the programme - physiotherapy, speech/language therapy, and developmental and cognitive therapy. This administrative structure was discussed with the whole staff before it was implemented. 'The staff was very happy about that. They trust these people and they know that they will represent their wishes. So instead of things being decided cooperatively by fifty staff, they are now decided in a smaller group which others have input into.' This smaller group includes someone representing all those involved in the preschool work that encompasses transitions to preschool and work in the centre's preschool. There is also a representative of those involved in the family support work done by the centre. The management team meets with the director of the centre once a week.

Each of the strands of the programme has regular staff meetings and then there is a general meeting for everyone working at the centre once every two months. This meeting is a time when staff is encouraged to speak about anything that is of concern to them. It is also a forum at which directions for the future are discussed. The senior management also meet regularly with staff in what are referred to as 'discipline groups' (physiotherapy, speech/language therapy etc.) and out of those meetings may come ideas that one person may put to the larger group.

Much of Patricia's work still involves contact with government ministries, departments and agencies. The frustrations involved in this networking flow out of the constant restructuring of government agencies responsible for health, disability, education and child welfare. Some of them are the outcome of movements of staff working in these fields between different government departments and agencies. Patricia spoke about her interaction with public servants:

They want information about something, and you do it all, but then that person is no longer there. So you encounter someone who says, 'Now what was all this about again?' The upside is that the separateness allows you to be clinically self-determining to a large extent and to make your own culture. The downside is that you are at the mercy of all of this. And you are at the mercy of the Education Service, Child, Youth and Family Services ... you name it.

### **The challenge of the Treaty of Waitangi: work with Ngai Tahu**

The centre has recently been thinking hard about the appropriateness of its services for Maori children and their families and how they might better work with Ngai Tahu to provide a service that is consistent with a commitment to the Treaty of Waitangi. Patricia indicates that those working at the centre and on the trust board have been 'very careful to walk the walk that Ngai Tahu will sanction. Funnily enough when the managers from the Women and Child Health at Ngai Tahu come to talk to us about their vision for women and children's health and what that means in terms of kaupapa Maori, our language and their language were very similar.'

The Early Intervention Programme has always had a whanau approach to work with children with special needs. It has always seen work with the child as work with a family. The centre has a whanau room, but at this stage it is not in a position to offer an alternative Maori programme. However, offering the programme in a slightly different form facilitated by a Maori professional is a distinct possibility. Maori have not on the whole qualified as physiotherapists and speech and language therapists. There is a student currently in Speech and Language Therapy programme who has already been already identified as a possible recruit in the future, but Maori have not traditionally trained in these areas and this makes it difficult to recruit people with clinical experience. 'In theory it is wide open, but in practice it is just difficult to hire staff who are Maori.'

Links have been established with Maurice Grey and Ngai Tahu, and he has indicated that he would help in any way he could. 'If we have a Maori family, we just need to ring him and he will supply a kuia or kaumatua as support person for them.' Just as the centre has to embrace new practices with respect to recruiting full-time workers, so it also has to embrace kaupapa Maori.

### **Assessing the present, considering the future**

For over twenty years the Early Intervention Programme has relied primarily on a team of part-time dedicated professionals who were often recruited through personal networks rather than through formal job advertisements. These professionals often worked in the programme for ten or more years, sometimes returning to work after time off caring for their own children. Pioneers in this field, they embraced a multidisciplinary approach and adopted strategies informed by an ecological approach to learning and a focus on the significance of parents/caregivers as those who most closely interacted with these children on a day-by-day basis. The professionals involved in this initiative were committed to intervening as early as possible in the lives of children who were diagnosed with Down's Syndrome, cerebral palsy or other conditions that might affect children's



capacity to learn and participate fully in mainstream education. The focus throughout was on the rights of these children to interventions that would maximise their learning of speech and language, cognitive skills and motor skills. Ground breaking work was done in the integration of children who used the centre into kindergartens, playcentres and schools. This work has expanded, and the demand for it has been thoroughly demonstrated, but as director of the centre, Patricia Champion is convinced that changes are necessary if the programme is to survive. 'Rightly or wrongly I think that the organisational culture that we have had has to change, and if it doesn't change now then it will die.'

Many of the staff recruited in the 1980s and 1990s will start retiring during the next five to ten years. It is highly unlikely that they can be replaced by others who are prepared to undertake demanding professional work on a part-time basis for low pay. The imperatives that drive younger professional women are different from those that shaped the commitment and dedication that an older generation of female physiotherapists, speech therapists, psychologists and early education experts brought to the programme. According to Patricia, 'It is about newer and younger people having student loans and so how much money they earn is incredibly important to them.' Recruitment of a new generation of professionals to staff the centre requires providing well paid full-time work with good conditions of employment. Vocation, dedication and determination to make a difference in a marginalised field on work will not be enough to attract skilled people to work in the center in the future. A new generation of speech therapists, psychologists, physiotherapists etc. are also sometimes the sole or major earners in their households. They need to find secure full-time employment.

When the centre started it was a huge challenge to what existed, in terms of what was possible for the children and parents who used its services. Staff knew that if they did not contribute to the work of the centre, and if they didn't give the extra ounce of their time and do voluntary work, on top of their paid work, these opportunities would not be available. Now the inclusion of children with disabilities and deinstitutionalisation is the major paradigm, the dominant discourse. As Patricia put it, 'There is not the same challenge to get over the mountain.' But she also argues that professionals working in this field now have different motivations, including attention to their own career development and their rights to certain levels of remuneration. They need to think about their career paths and their work is less framed by the discourses of 'service', 'vocation' and 'making a difference'. According to Patricia this is not something that should be judged, but it is something that must affect planning for the centre in the future.

In order to continue to be 'a player' in the early intervention field the programme will need to replace retiring professionals in part-time positions with people in full-time jobs. According to Patricia, this is necessary if 'we are to keep ahead of the action, not behind.' The centre will eventually employ fewer people, but more of them will work full-time. This will enhance the possibility of recruiting new graduates from speech and language therapy programmes as well as other training courses. It will also be a way of recruiting other more experienced professionals who want and/or need full-time employment.

Work towards a different orientation to recruitment started at the beginning of 2000 with the hiring of three new graduates on an intern system. They are paid at the same rate others working at the centre, but their take home pay is higher because they are hired on a full-time basis. Even though they are paid at the same rate as senior professionals at the Champion Centre, they still probably earn less than they would in other jobs as new graduates. However, they would not get the rich experience and support from senior staff in some other employment contexts. This was the first move by the Champion Centre to offer full-time work to those working in the clinical field. Newly qualified professionals are certainly interested in working at the centre. Despite the fact that the Champion Centre could not offer the highest rates of remuneration, the top seven speech and language therapy graduates applied for the internship position. The job was seen as a professional opportunity, particularly an opportunity to work in a multidisciplinary team with a group of senior and supportive colleagues. Some new graduates sometimes have to work in professional isolation.

At the time the interviews were conducted, Patricia Champion was hoping that the centre would get enough money to create continuing full-time clinical positions. This development will create significant ongoing differentials between newly appointed relatively junior staff and senior part-time staff. However, the staff have been consulted on this development and they have indicated that they accept that this is the way it is going to be if the centre is to survive and be adequately staffed in the future. Staff currently employed will have the opportunity to apply for new full-time positions, but many of the current staff do not want full-time employment.

Another core issue is forming strategic alliances that could ensure the future of the programme, particularly alliances with those working in field of health rather than education and disability. The reconstitution of the two CHEs under a single district health board means that mental health services will be better integrated with other services and paediatric services and child mental health will also be better integrated. That would be consistent with the multidisciplinary work of the centre. In this context the challenge is to sustain networking and connections to people who are key sources of information and resources. According to Patricia, 'You can get sympathy for your point of view so that you have some 'friends at court' so to speak'.

One possibility for the Champion Centre is to operate as a unit within the Department of Paediatrics with its own director and a set of research projects associated with it. Patricia indicated that:

It is a matter of what we have to offer and what we have to sell. I'm thinking at the moment that we should remain a charitable trust and that we again challenge this city to maintain our independence, but have a very detailed memorandum of understanding about how we would operate. We would need to talk very carefully about what our values are and what was not negotiable in terms of those values.

There is also a need to consider selling the services of the centre to the Clinical Training Agency. Patricia argues that, 'We want to remain the dominant player, not the only player, it is a very competitive environment and there have to be other players. But we still

believe that we are the dominant player on the basis of history, numbers and clinical practice. And the children need us to be that, otherwise they won't be well served.'

There is also the possibility of expanding the current composition of the Early Intervention Trust Board. At the time of the interviews Patricia Champion wanted to recruit a woman to the board who was 'a mover and changer', ideally someone who had some experience within the business community. She was interested in staff and trust board members who 'can embrace others' passion and vision'.

Recruiting someone to eventually replace her in the position of director of the Champion Centre is also a key issue for the current director. The person who replaces her needs to be someone committed and energetic, with both clinical and management experience. If she was relieved from the responsibilities of the position of director, Patricia sees herself engaging in research, writing, and small group teaching, but also acting as a mentor to new clinicians. She already has a position at the Christchurch School of Medicine, and would expect to continue in that position. She is currently involved in several research groups and has acted as a clinical consultant doing supervision. 'But what I really want to get out of doing ... is constantly asking: 'Who do I have to talk to?' 'Where is the money going to come from?' Patricia would like to have more time working out 'what is the literature saying and how that translates into practice'. She said, 'I'm still fascinated by ideas and I'm still charged by that sort of thinking, but I'm bored rigid by bureaucracy, bored rigid!'

## **Epilogue**

The Champion Centre has just moved into a newly renovated, stand-alone facility in the grounds of Burwood Hospital with easy ground floor access and outdoor playing areas. Simultaneously, a new district health board is undertaking the administration of health services in Canterbury and new professionals are entering work in the field of early intervention with children with actual or potential special learning needs. Against the background of these developments, and other anticipated changes for the Champion Centre, Patricia Champion agreed to talk to a sociologist about the history of this early intervention programme in Christchurch and her vision for its future.

This narrative is a contribution to the process of conceptual stocktaking that is currently occurring among staff and those involved in the Early Intervention Trust. It is also a case study of innovation in a particular context. It highlights the intersection of intellectual work, research questions, social justice agendas, organisational conventions, professional and personal networks, passion, persistence and contingent opportunity that facilitate, and at times frustrate, the endeavours of individuals who want to effect change in their communities. This is not the only story that could be told about the Champion Centre and the factors that have shaped its development over the last twenty years. Many people have been involved in the work of the centre and many stories could be told about the work that has gone on in that environment. Collective community-based endeavours depend on the energy and diverse input of many individuals. While vision and principle are the basis for their establishment, they survive because they are responsive to opportunities and embedded in complex networks that cut across established institutions. This story documents the way in which a particular innovation developed against the background of access to ideas and new research, political commitment, personal networks, gendered professional work, resource availability, state sector restructuring and organisational innovation. It also highlights the significance of individual life trajectories in the process of implementing change in the provision of education, health, and psychological services for children with special needs.