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Family-Centered Services

Article Summary: Hammill Institute on Disabilities /Topics in Early Childhood Special Education 21(4) 216-223 (2012)

As the Office of Special Education Programs begins its shift towards results-driven accountability (RDA), measuring the effectiveness of programs that serve young children and their families has become a priority. In the past, accountability was focused on whether or not children and families received services to which they are entitled and on the attainment of goals and objectives. In 2005, OSEP began requiring states to report the percentage of children who demonstrate improvements in three global child outcome areas:

- (a) Positive social-emotional skills
- (b) Acquire and use knowledge and skills
- (c) Use appropriate behavior to meet their needs

Public Law 99-457 recognized the unique role of families in the development of young children with disabilities and emphasizes family support as a focus of Part C and Part B/619 programs. Public Law 99-457, known as the Individuals with Disabilities Education Act (IDEA) requires the Individualized Family Service Plan (IFSP) be developed with the family and may contain both family and child outcomes and services. For nearly 30 years, experts in the field have known that a family-centered approach must be a central component of any program serving young children with disabilities and that “family benefit” is a desired outcome. Current research ranging from small and focused research projects to meta-analyses of multiple large data sets demonstrates that when family outcomes improve, child outcomes improve as well, and it is “well accepted that the nature and quality of parent-child interactions

and family-orchestrated child experiences are powerful determinants of child development (Guralnick, 2005; Head & Abbeduto, 2007; Warren & Brady, 2007).

Family-centered practices were adopted as recommended practices by various professional and scientific groups, including the Institute of Medicine (2001), the American Academy of Pediatrics (2003), EI and ECSE (2005), the American Hospital Association (2009), and the American Speech-Language-Hearing Association (2008), among others. Studies in pediatric practice have shown that a family-centered approach improved physical, psychological, developmental, and health outcomes for children (Gooding et al., 2011) and some evidence of this is available in EI programs (Dunst & Trivette, 2009; Raspa et al., 2010).

In the decades following the passage of IDEA, much work has been done by the Office of Special Education Programs (OSEP) and OSEP-funded national TA providers to support states’ Part C programs in supporting parents and other caregivers to help their child develop and learn and supporting Part C programs in documenting family outcomes. However, despite almost universal recognition and recommendation, implementing a family-centered approach has been a challenge due in large part to competing advocacy efforts that focus on enhancing access to and the amount of services for children rather than a focus on improving overall family outcomes and the quality of services provided to the child’s adult caregivers.

article summary continued on page 2

Family-Centered Services, *continued*

Other factors such as leadership, training, attitudes, and lack of resources also impact implementation (Gooding 2011).

A *family-centered approach* is not the same thing as a *family outcome*. A family-centered approach is a **philosophy** and **set of practices** that characterize service delivery. A family outcome is a benefit that families receive as a result of participating in early intervention. OSEP requires states to report data on family outcomes developed by the Early Childhood Outcomes (ECO) Center with substantial national stakeholder involvement. These outcomes are documented as the percent of families who report that early intervention helped them:

- (a) know and understand their rights
- (b) communicate their child's needs
- (c) help their child develop and learn

So what is "family-centered" practice or approach?

Family-centered practices aren't a "service delivery model," it's a belief system that inform how all members of an EI program work with children in the context of their unique family. A key component of family-centered practice is that young children are not viewed separately from their families, nor can services be provided without consideration of family context. Families are not viewed as clients receiving services but as partners in making decisions about goals and the activities to reach those goals, and programs adopt a flexible approach to service provision. In family-centered practices, there is a focus on family strengths and using those strengths to support positive child and family outcomes. The importance of informal support systems is recognized and considered when selecting services and their frequency.

Arkansas' Guide to Promoting Family Engagement: A Resource for Early Childhood Professionals

Developed by the Arkansas State Parent Advisory Council in collaboration with the Arkansas Head Start State Collaboration Office and the Division of Childcare and Early Childhood Education, the guide offers a statewide system for promoting family engagement to meet the needs of young children and families in Arkansas. The guide, intended to support families' active engagement in their children's development and education, demonstrates the state's commitment to support its youngest learners and their families. When children and their families experience success in the earliest years, they will have a stronger foundation for continued success in school and later.

Guiding Principles:

1. Family engagement practices respect parents as their child's first teacher and recognize their importance in school readiness and later success in life.
2. Families are unique. We appreciate and celebrate all differences. Family engagement activities will demonstrate regard for different ways of knowing, doing or being, and will build on family strengths.
3. Positive two-way communication must be modeled in order to build trust and relationships with all partners, including encouraging family-to-family interaction. Family engagement should create a safe environment where all questions are welcomed and ideas embraced.
4. The practice of engaging families must be achievable and sustainable. In order to support early childhood programs, current and proposed state-level early childhood and school age policies should be reviewed for their potential impact on the family engagement goals articulated in this guide.
5. Family engagement practices should create meaningful and ongoing opportunities for families to serve in leadership roles.

To attend an upcoming training on using the Family Engagement Guide, visit the TAPP Registry at:

<http://professionalregistry.astate.edu/registry.asp>

Hot Springs: July 21

Fort Smith: August 11

Jonesboro: Sept 22

Springdale: Sept 29

Pine Bluff: October 5

Forrest City and Hope (TBA)



FGRBI Model

More of an approach than a model, Family-Guided Routines-Based Intervention (FGRBI) integrates published literature on interventions embedded within typical child and family activities or routines (Bricker & Woods Cripe, 1992; Bruder, 1998; Dunst, Bruder, Trivette, Raab, & MacLean, 2001; Hanft & Pilkington, 2000; McWilliam, 1996; 2001; Woods, Kashinath & Goldstein, 2004; Friedman, Woods & Salisbury, 2012; Marturana & Woods, 2012) to meet the spirit of natural environments legislation. The FGRBI model includes the following processes.

Process 1: Introducing Natural Environments & Welcoming the Family

Family members are just as unfamiliar with “natural environment” and principals of family-guided routines-based intervention as many providers are. Sharing information with caregivers and family members about the early intervention process and program expectations sets the stage for active family and caregiver participation in intervention.

Process 2: Routines-based Assessment in Natural Environments

A functional assessment occurs in a variety of naturally occurring daily routines within the child’s natural environment. The process accommodates the priorities and concerns of families by encouraging families to share information about routines and activities most appropriate for and preferred by the child and family.

Process 3: Linking Assessment to Intervention

The quality of routines-based intervention depends on the creation of a functional and useful intervention plan that is meaningful to the family. The child’s IFSP

outcomes must reflect the skills necessary to function in the routines and activities identified as important to the family. The teaching and learning opportunities (strategies) must be planned to correspond to locations, activities, and interests of the child, not missed evaluation items or toys from the therapist’s toy bag.

Process 4: Involving Caregivers in Teaching and Learning

The basic premise of natural environments is involving the caregiver in the teaching and learning process with the child. It is crucial to identify ways to share information with diverse caregivers about various teaching strategies in ways that match their learning styles. Caregiver involvement in intervention ensures that the child’s adult caregivers can use these strategies within typical activities to promote their child’s learning and skill development.

Process 5: Coaching

The purpose of caregiver coaching is for the EI provider to effectively collaborate with the caregivers in order to better support caregiver-child interactions that promote child learning. Caregiver coaching is the primary role of the EI provider to enhance caregiver capacity to help the child develop and learn (OSEP Family Outcome).

Process 6: Monitoring Progress

The effectiveness of the strategies being used to reach IFSP goals is assessed continuously and with each family to ensure a “good fit” and ease of caregiver implementation. Information should be gathered from a variety of sources and family and child outcomes must be reviewed consistently to ensure the priorities continue to reflect child and family concerns.

FGRBI Resources:

“4 Family Stories” complete with child outcomes planning sheets: <http://facets.lsi.ku.edu/family-stories>

FACETS: 5 Free, Self-Paced Training Modules: <http://facets.lsi.ku.edu/training-modules>

TaCTICS: 4 Free, Self-Paced Training Modules w/ Tools/Handouts: <http://tactics.fsu.edu/modules.html>



Questions from the field . . .

And answers from Arkansas Medicaid Therapy Provider Manual

Q: Can swallowing be treated prior to a Video Swallow Study? Can I treat stand alone Oral Motor even if intelligibility is not affected? If the child is too hypersensitive to complete testing for oral motor, does this alone qualify the child?

A: Swallowing is only treated after the Video Swallow Study is obtained. You may treat stand alone Oral Motor as long as an in-depth functional profile of oral motor is documented justifying the medical necessity of therapy. Documentation needs to be noted for severe, moderate, or mild. If a child is too hypersensitive to complete testing, the inability to complete testing is not adequate to establish medical necessity, but note in the report the inability to complete the test and provide in-depth documentation of other findings. (p. 6)

Did YOU Know?

An interim IFSP can assist a family in receiving early intervention services to meet immediate needs for an eligible child before and the completion of the evaluation and assessment, if the following conditions are met:

- parent consent is obtained and intake completed.
- an Interim Individual Family Service Plan is developed with the family. The interim IFSP includes the name of the Service Coordinator who will be responsible for implementation of the Interim IFSP and coordination with other agencies functional child outcomes (a few critical goals and objectives) and the early intervention services that have been determined to be needed immediately by the child and the child's family to reach critical family goals.
- the evaluation/assessment is completed within the 45 day time period required, eligibility is established, and the complete IFSP is developed.

Interim IFSPs are most frequently used for a new referral when eligibility is already known/determined. For example, an interim IFSP can be developed to meet immediate needs for a child referred to Part C who has a medical diagnosis of a condition likely to result in developmental delay (see AR#3000/Eligibility) or a family moving to Arkansas from another state with an active IFSP (Informed Clinical Opinion/Records review of evaluation reports, IFSP, progress notes would help the team determine eligibility).

Washington has published a joint policy statement May 5, 2016 to provide recommendations to early childhood systems and programs on family engagement. Family engagement refers to the systematic inclusion of families in activities and programs that promote children's development, learning, and wellness.

“The lives and experiences of young children are intertwined with those of their families. Families are children’s first and most important teachers, advocates, and nurturers. Strong family engagement in early childhood systems and programs is central—not supplemental—to promoting children’s healthy intellectual, physical, and social-emotional development; preparing children for school; and supporting academic achievement in elementary school and beyond. Research indicates that families’ involvement in children’s learning and development impacts lifelong health, developmental, and academic outcomes. Family engagement in early childhood systems and programs supports families as they teach, nurture, and advocate for their children, and in turn, family engagement supports and improves the early childhood systems that care for and teach children.”

For family engagement to be integrated throughout early childhood systems and programs, providers and schools must engage families as essential partners when providing services that promote children's learning and development, nurture positive relationships between families and staff, and support families. The term “family” as used in this statement is inclusive of all adults who interact with early childhood systems in support of a child.

