The Individualized Family Service Plan: A Family-Centred Approach to Working with Families Who have a Child with a Disability

by

Tricia Lee Klassen

A Practicum

Submitted to the Faculty of Graduate Studies

of the

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In partial fulfillment of the requirements

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ABSTRACT

Within the area of child disability, a family-centred philosophy to service has been established which attempts to address the needs of all family members. The Individualized Family Service Plan (IFSP) is a service-planning process, which ideally results in a comprehensive description of the needs and goals of the child and the family, and functions as a guide to strategic intervention planning. The IFSP is based upon the premise that each family is unique, that families are experts of their own situations, and that parents should be viewed as equal partners in the planning process.

The student met with families who receive services from Children's Special Services to develop IFSP's and to determine family preferences regarding various aspects of the process. Family service workers participated in order to receive consultation on techniques to develop rapport with families, to carry out comprehensive assessments using both formal and informal methods, and to develop IFSP documents.

The student discovered that families find the IFSP process beneficial, particularly when experiencing life transitions. As families are unique and are impacted by disability in a variety of ways, the process must be flexible and respond to families' changing needs. A comprehensive assessment of child and family needs is a vital component to understanding both strengths and resources, and barriers to achieving family-defined goals. Utilizing standardized measures can be a non-intrusive way of gathering information as families are encouraged to expand upon areas that are relevant to them. Furthermore,

IFSP's which are written in family-friendly language and outline specific measurable goals are more likely to be found helpful to families and to facilitate family empowerment. The provision of training to both professionals and parents outlining the principles of family-centred practice and the IFSP process is critical to ensuring effective planning.

CHAPTER I

INTRODUCTION

The rationale for the provision of early intervention services to families who have children with disabilities has traditionally been to enhance child development. Within the past decade, both professionals and parents have begun to recognize that working with families is justifiable on the basis of supporting the family, regardless of whether that support is a direct enhancement of the child's progress (Bailey, McWilliam, Darkes, Hebbeler, Simeonsson, Spiker, & Wagner, 1998). Furthermore, systems theory has contributed to the recognition that children develop within the context of a family environment. A family-centred philosophy to early intervention has emerged which attempts to address the needs of all members, involves partnership between professionals and families, and recognizes families as experts of their own situations (Bradley, Parette, & VanBiervliet, 1995; Farel, Shackelford, & Hurth, 1997; Notari & Drinkwater, 1991).

Although the family-centered philosophy has been embraced in the childhood disability field, actual services do not always reflect these values (Katz & Scarpati, 1995). However, family-centred values can be promoted by the utilization of the Individualized Family Service Plan (IFSP). The IFSP is a planning process which incorporates family concerns and priorities, encourages equal participation of family members, and emphasizes child and family strengths (Boone, Moore, & Coulter, 1995). The implementation of an IFSP is intended to meet the needs of all family members by identifying the needs, strengths, and goals of families and

functioning as a guide to strategic intervention planning (Moroz & Allen-Meares, 1991).

Although the IFSP is mandated as a vital component of family-centred early intervention services in the United States (Beckman, 1991), Canada has no comparable legislation. However, Children's Special Services in Manitoba has recently developed a policy which requires that case workers develop IFSP's with all newly referred families. As families access the service system at various life stages, it is important that the IFSP process respond to families' ongoing concerns and priorities, beyond the early intervention phase.

Goals of the Practicum

The purpose of this practicum was to assist in the development of services which meet the needs of both children and families who are impacted by disability. Through the development of several IFSP's, this student hoped to determine various ways in which the service system may address family concerns and support family strengths. Knowledge gained through this process contributed to current research being conducted in Manitoba. Furthermore, the practicum served as a training tool for service providers, some of whom participated in the practicum, others who received information on practicum findings. Thus, three primary goals were established:

a) To influence the manner in which the service system currently responds to families who have children with disabilities in their home.

b) To empower families to be an integral part of the service planning process, including child and family assessments, development of IFSP's, and implementation of IFSP's.

c) To develop IFSP's which are sensitive to family diversity by considering culture, socioeconomic status, and family structure.

Educational Goals

As the purpose of a practicum is to enhance one's clinical knowledge and skills, various educational goals were identified, which included:

a) To develop an understanding of families' experience with disability within the context of systems theory.

b) To gain experience in the family-centred approach to intervention with families who have a child with a disability.

c) To enhance knowledge of preferred practices, techniques, and expectations related to the development of IFSP's.

d) To determine the applicability of various assessment techniques to assessing needs and strengths of this population, including various standardized and non-standardized approaches.

e) To determine the response of case managers to their involvement in the process, and to make recommendations for future methods of consultation regarding implementing the IFSP model.

Committee Members

Three committee members guided this student in carrying out the practicum. Dr. Barry Trute acted as the primary advisor. Dr. Trute is a Professor in the Faculty of Social Work at the University of Manitoba and in the School of Social Work at McGill University. Dr. Diane Hiebert-Murphy acted as the faculty representative for the practicum. Dr. Hiebert-Murphy is an Assistant Professor in the Faculty of Social Work and Associate Director of the Psychological Service Centre at the University of Manitoba. Dr. Trute and Dr. Hiebert-Murphy are principle investigator and co-investigator, respectively, for the Family Strengths in Childhood Disability (FSCD) Project. Ms. Kathy Levine acted as the agency

representative for the practicum. Ms. Levine is in doctoral studies at the University of Manitoba in the Faculty of Social Work, works as a social worker with the Child Guidance Clinic in Winnipeg, and is the research coordinator for the FSCD Project.

Relevance to Social Work

Factors such as deinstitutionalization of individuals with disabilities and normalization theory have contributed to the recognition that children develop within the context of the family system (Bradley, 2000). As a member of the family, the child with a disability has an effect on each of the family members and upon the family unit itself (Lynch & Morely, 1995). Despite the likelihood of these families experiencing a greater number of stressful events, however, research has found that these stresses typically do not result in family dysfunction (Mahoney, O'Sullivan, & Robinson, 1992).

It is apparent that the family-centred approach reflects both a systems and strengths perspective of childhood disability, recognizing both the interdependent nature of the family system and the ability of families to meet their own needs when supported. Several authors have proposed that social work is a logical discipline to develop knowledge of the systemic nature of families, promote and understand principles of family strength, and understand the need for parent-professional interdisciplinary collaboration (Malone, McKinsey, Thyer, & Straka, 2000). As social workers typically coordinate services for families who have children with disabilities, it is vital that they have the knowledge and skills to implement family-centred interventions.

CHAPTER II

LITERATURE REVIEW

The Family-Centred Model

Family-centred service is the term that refers to a constellation of new philosophies, attitudes, and approaches to providing support to families who have children with diverse health needs (Rosenbaum, King, Law, King, & Evans, 1998). The family-centred model characterizes an approach to services which involves partnership between professionals and families, supportive and respectful treatment, and the exchange of information (King, Rosenbaum, & King, 1997). Numerous literature on the principles of family-centred intervention stress that in order to be truly family-centred, services must involve parents as equal collaborators who hold equal decision-making powers and are recognized as experts of their own situations (Farel, Shackelford, & Hurth, 1997; Bradley, Parette, & VanBiervliet, 1995; Notari & Drinkwater, 1991). Lubetsky, Mueller, Madden, Walker, and Len (1995) suggest that the family-centred approach addresses challenges within the family system, clarifying the role of family members, exploring the interaction of the family with community services, educating the family to make informed decisions about their child's programs, and assisting parents to become advocates for their child.

Although limited research has been conducted on the relationship between family-centred services and positive family functioning, a recent study found that parents who perceived services as family-centred experienced less parental distress (King, King, Rosenbaum, & Goffin, 1999). Furthermore, various research

on family preferences in receiving service have found that families feel more empowered to participate when professionals recognize the knowledge they hold of their children and encourage parental decision-making (Campbell & Strickland, 1992; Summers & Turnbull, 1990).

The Family Systems Approach

The recent shift to a family-centred model of care is derived from the recognition of the relevance of a family systems approach to understanding development. The systems approach primarily recognizes that the family is the constant in a child's life (Rosenbaum et al., 1998). Furthermore, as a member of a family, the child with a disability has an effect on each of the other family members and upon the family unit itself (Lynch & Morley, 1995). Minuchin (1974) asserted that "an individual within a family responds to stresses in other parts of the system to which he adapts; and he may contribute significantly to stressing other members of the system" (p. 9). Clearly, the family system is interactive, interdependent, and reactive, in that all members of the system are effected by characteristics of one member.

Seligman and Darling (1997) distinguish family systems theory from earlier perceptions of family life as being characterized by linear relationships in which the only important relationship was seen as between the mother and her child. Systems theory recognizes the family as being characterized by a group of individuals and the pattern of relationships between them (Patterson & Garwick, 1994). The three perspectives on family dynamics which are described within the context of family systems theory include family structure, family functioning, and the family life cycle.

Family Structure

Family structure is defined as the various characteristics that contribute to the family system (Seligman & Darling, 1997). The characteristics of family structure which are most prominent in the literature as impacting upon a family's response to disability include family member roles, membership characteristics, cultural values, and ideology.

Patterson and Garwick (1994) advise that the individuals within the family system make up the structure, set apart by others by a semi-permeable boundary so that persons, information, and services can exit and enter the system. When a member of a family has a chronic condition such as a developmental disability, boundary ambiguity may be present. The individual with a disability may be physically present, but not contribute to the family in the same way as other members. Additionally, the constant presence of service providers in the home, such as respite and health care workers may add ambiguity to the family structure (Patterson & Garwick, 1994).

Seligman and Darling (1997) advise that membership characteristics such as the number of parents in the home, the presence of extended family, the employment status of parents, and psychological disorders of family members impact upon the structure and functioning of families who have a disabled member. Numerous studies have found that two-parent families, parental education, high socioeconomic status, less children, and older parents are familial characteristics that are correlated with family strength in this population(Friedrich et al., 1985; Sloman & Konstantareas, 1990; Trute, 1990). Bradley et al. (1995) advise that family demographics be considered in the initial phase of family assessment.

A family's ability to adapt to childhood disability is partially determined by the degree of chaos and rigidity in the family. Role assignment is a normal component of the family system. However, parents of children with disabilities are often expected to assume various roles, including service developers, teachers, advocates, and decision makers (Turnbull & Turnbull, 1990). When roles are rigid and inflexible, families are unsure of how to define each family member's role (Bailey, Palsha, & Simeonsson, 1991). In many families, the care giving responsibilities will be assigned to the mother, which may result in an overburden of the mother and marginalization of the father. Trute (1995) asserts that households with children with disabilities are more likely to be "traditionally structured" which may be due to a significant increase in child-care demands. In addition, siblings may need to be assigned roles that would not have been assumed otherwise (Malone et al., 2000). Well-functioning families achieve a balanced interaction which is neither unstable, inconsistent, and chaotic, nor governed by rigid rules which do not change in response to stress (Lynch & Morley, 1995).

Although culture is a suprasystem which extends beyond the family system, culturally based beliefs may influence the manner in which family members adapt to a child with a disability (Lynch & Morley, 1995). The cultural style of the family may be influenced by ethnic, racial, and religious factors, and socioeconomic status (Lynch & Morley, 1995). Cultural beliefs are probably the most consistent component of a family (Lubesky et al., 1995). Thus, one's beliefs may be challenged following the birth of a child with a disability. Although little information is available on cultural variations in response to childhood disability, the study of various cultures suggests that certain cultural attitudes and cognitions impact upon one's response to stress (Shapiro & Tittle, 1986). For example, Mexican American families tend to have a more relaxed attitude towards achievement of

developmental milestones than the dominant culture (Turnbull & Turnbull, 1990). Cultural beliefs may also influence a family's response to service systems (Seligman & Darling, 1997). In low-income minority families, the unequal distribution of power between professionals and parents may be perceived as greater, resulting in a hesitancy to utilize available services.

Ideology is based upon a family's beliefs, values, coping behaviors, and cultural beliefs (Seligman & Darling, 1997). Lynch and Morley (1995) advise that families frequently must confront their beliefs about what and who is in control of life events in order to adapt to having a family member with a disability. For many families, the thought of having produced a child with such challenges can result in a threat to the parents' sense of self (Sloman & Konstantareas, 1990). Families who blame others or feel a large degree of guilt and shame will have a more difficult time adapting to the disability (Seligman & Darling, 1997).

Family Functioning

Family functioning refers to the patterns of relationships which connect individual family members (Patterson & Garwick, 1994). Bradley et al. (1995) describe family functioning as a broad array of ways in which families meet their individual needs. Typical families carry out a broad array of functions in areas such as economic, domestic, health care, recreation, socialization, self-identity, affection, educational and vocational (Seligman & Darling, 1997). Families who have a member with a disability may have depleted resources in carrying out these functions. The presence of a child with a disability in the family may place excessive demands on the resources of the family, resulting in an unequal flow of energy into and out of the family (Bubolz & Whiren, 1984). Bradley et al. (1995) assert that families only have so much energy to direct at meeting their needs and

require from external systems the kind of input that enables them to most effectively utilize their own internal resources.

Apparent in the literature are various types of strains on families who have a child with a disability that potentially interrupt healthy family functioning. Stresses experienced by these families may include financial strain (e.g., home modifications, leaving the workforce to care for the child), problems with service providers, loss of family privacy, limitations in family and social activities, disruption of normal household functioning, marital strain, care giving strains, difficulties for siblings, worries about the future, and pressures of constant decision making (Marsh, 1992; Patterson & Garwick, 1994; Seligman & Darling, 1997). Lynch and Morley (1995) assert that the disability may result in a modification of functions, roles, and priorities, particularly as the time required to carry out routine functions may increase.

The Family Adjustment and Adaptation Response Model (FAAR) asserts that families attempt to maintain balanced functioning by using their capacities (resources and coping behaviors) to meet their demands (stressors and strains) (Patterson & Garwick, 1994; Seligman & Darling, 1997). A major stressor such as child disability creates demands upon the family which requires adjustment and adaptation. In adjusting to the disability, the family will attempt to use existing capabilities to meet the new demands. Adaptation to the stressor can only occur once new resources and coping behaviors have been acquired, demands have been reduced, and the family has found new meaning in their situation, themselves, or the world (Patterson & Garwick, 1994).

Families can develop both internal and external resources to adapt to the stresses associated with having a child with a disability. Internal resources include coping strategies which focus on one's perception of a situation, while external resources include coping by relying on social support, spiritual support, and formal

support (Seligman & Darling, 1997). Coping is defined as a specific effort by an individual or family that is directed at maintaining or restoring the balance between one's demands and resources (Patterson & Garwick, 1994). Thus, families may cope with stress by relying on personal, family, or community resources.

As indicated, internal coping strategies refer to one's perceptions of the impact of circumstances on one's ability to function. Stress is not inherent in an event but is conceptualized as a function of the response of the family member (McCubbin, Joy, Cauble, Comeau, Patterson, & Needles, 1980). Friedrich, Wilturner, and Cohen (1985) assert that positive coping occurs when families are able to mobilize appropriate coping processes as a result of adaptive appraisal. Turnbull and Turnbull (1990) refer to the ability to positively redefine a situation as reframing. Individuals who engage in this style of action-oriented coping are more likely to function positively than those who use emotion-focused strategies. Shapiro and Tittle (1986) assert that coping is not a unitary concept, but is comprised of many different behavioral, cognitive, and affective components.

Judge (1998) found a relationship between active problem solving, reliance on social support, efforts to alter stressful situations and family strength. Friedrich et al. (1985) reported that mothers who were not depressed and had an internal locus of control reported less family problems. Various intrapsychic and action-oriented efforts to manage excessive demands have been found to predict positive family functioning. These strategies include acceptance and understanding of the disability, secure family relationships, utilizing informal supports, use of a large number of coping strategies, marital satisfaction, involvement in the child's service plan, and initiating family therapy and other services (Judge, 1998; Lynch & Morley, 1995; Palfrey, Walker, Butler, & Singer, 1989; Sloman & Konstantareas, 1990).

The quality of external resources, which include community resources and family supports available to families also appears to have a major impact on the family's ability to cope (Boyer, 1986; Sloman & Konstantareas, 1990). Seligman and Darling (1997) report that social support is an external coping strategy that has been shown to reduce family stress. Valentine (1993) defines social support as including emotional, physical, informational, instrumental, and material aid and assistance. Olsen and Marshall (1999) assert that families can utilize two support system networks, which include informal and formal supports.

A family's informal support network can be comprised of relatives, friends, neighbors, co-workers, and social groups who share material goods, services, emotional support, intimacy, affection, and information (Valentine, 1993). Seligman and Darling (1997) assert that childhood disability can have an isolating effect on families. Olsen and Marshall (1999) support this claim, advising that often parents of children with disabilities receive decreased levels of support as individuals in their support network are unsure of how to help, thus, withdraw. The withdrawal of informal supports often occurs when instrumental supports, such as child care and transportation needs are high, and when increased expenses and stressors are present in the family (Olsen & Marshall, 1999). Herman and Thompson (1995) found that families who had access to other parents who were seen as helpful perceived their basic and child care needs as adequately met. Some parents experience a sense of relief when they discover other parents who have children with similar needs (Valentine, 1993). Thus, there is a need for formal services to assist families to develop greater informal networks.

Formal supports may include health care and social service agencies, early intervention programs, rehabilitation and developmental centres, adaptive equipment, day cares, the school system, financial support, and transportation services (Herman & Thompson, 1995; Valentine, 1993). Seligman and Darling

(1997) suggest that formal types of supports may be particularly crucial for families who have a very limited informal support network. However, families have expressed concerns about various aspects of formal services, indicating that professionals do not always listen to the needs of families, are often inflexible, communicate too formally and infrequently, and offer support that is not specific enough to families needs (Meyen & Skrtic, 1995).

Family Life Cycle

The family life cycle can be characterized as the progression of various life stages, including couplehood, birth and early childhood, school-age, adolescence, young adulthood, postparental, and aging (Seligman & Darling, 1997). These typical life stages can be related to the developmental stages of families who have a child with a disability (Lynch & Morley, 1994). These families tend to experience the same life transitions as other families, however, each transition may provide additional stressors as special considerations may need to be made regarding the needs of the child with a disability. For example, parents with adult children who cannot live independently may anticipate the postparental stage of their life as occuring later than families with typically developing children.

As families transition from one point in their life cycle to another, they tend to move from a period of relative stability through a period of change. These transitions typically cause stress which requires the reliance on both internal and external resources (Bradley et al., 1995). The involvement of new systems at each life stage may be a source of stress for families as they attempt to define the roles, responsibilities, and relationships within these systems (Malone, Manders, & Stewart, 1997).

The presence of a disability may impact upon the family's regulatory processes, leading to a distortion in family development (Patterson & Garwick, 1994). During

the months of pregnancy, parents develop a mental image of their child, which may need to be resolved following the birth of their child (Lynch & Morley, 1994; Malone et al., 1997). Many parents will experience some degree of grief in their attempts to cope with the loss of the anticipated child (Bailey et al., 1991). Sloman and Konstantareas (1990) suggest that the more typical the child appears, the more difficult the adjustment for parents, possibly resulting in a continuous seeking of a more favorable diagnosis. The experience that parents have with professionals will impact upon their ability to adjust to the disability. Seligman and Darling (1997) assert that professionals may treat parents like patients who need treatment rather than as experts as the child's caregivers.

Various models of grieving have been proposed, consisting of a range of three to seven stages. Although the notion of stage progression has been challenged (Sloman & Konstantareas, 1990), many authors suggest that parents may mourn the loss of a hoped for child by reacting initially with shock and eventual acceptance (Turnbull & Turnbull, 1990). However, Singer and Powers (1993) assert that there is a lack of understanding regarding a "typical" time course for disability-related grief and claim that there is no clear beginning or end to the grieving that parents may experience. At each stage of development, the family may need to re-address feelings of loss and grief as they are reminded of the impact of the disability upon the child's development (Malone et al., 1997; Shapiro & Tittle, 1986; Turnbull & Turnbull, 1990).

The Family Strengths Perspective

Family Systems theory effectively depicts the numerous effects that disability can have on each member of the family, and upon the family unit itself. As various authors suggest, the presence of a member with a disability may be a source of stress and may place excessive demands upon the family system

(Buboltz & Whiren, 1984). Despite some families' experiences of chronic stress and sorrow, however, many parents report that as a result of having a child with a disability, they have become stronger families, who recognize unique strengths in their child (Wikler, Wasow, & Hatfield, 1983). Marsh (1992) summarizes the numerous positive benefits associated with having a child with disabilities, which include strengthening of the family system, increased tolerance of diversity, opportunities for personal growth and fulfillment, and a greater appreciation for the accomplishments of the family member.

Mahoney, O'Sullivan, and Robinson (1992) indicate that although parents of children with disabilities are likely to experience a greater number of stressful events than families without a disabled member, these stresses typically do not result in family dysfunction. Furthermore, adjustment of the family is not typically related to specific characteristics of the child (Trute, 1990). Rather, families who positively adapt to their situation tend to have adjusted to the presence of the disability, are able to love the child for who he/she is, are satisfied in their marital relationship, utilize support networks, rely upon religious beliefs, and have emotionally well-adjusted children (Bennett & Deluca, 1996; Mahoney et al., 1992).

The family strengths perspective is concerned with enabling and empowering families to meet their own needs (Bradley et al., 1995). Empowerment can be defined as a process through which people become more able to influence the people and organizations that affect their lives and the lives of those they care about (Heflinger & Bickman, 1997). Heflinger and Bickman (1997) suggest that empowerment occurs when families act to change the condition of their lives and acquire the control necessary to manage their family affairs. Although the process of empowerment is complex, parents can not be empowered if parental choice and decision making is absent (Minke & Scott, 1993). Dunst, Trivette, and Deal

(1992) emphasize the role of professionals as creating opportunities for family members to acquire and display competencies that facilitate healthy family functioning. In order to make competent decisions, parents need access to resources, decision-making and problem-solving abilities, and skills to most effectively utilize available resources.

It is apparent that the family-centered approach to assisting families who have children with disabilities reflects both a systems and strengths perspective of childhood disability. A family-centred approach to developing IFSP's recognizes that despite the tendency for these families to experience additional stressors, families tend to function effectively, particularly within an atmosphere of parent-professional collaboration, respect, communication, and sensitivity.

The Individualized Family Service Plan

The implementation of family-centred intervention services is typically guided by the development of the Individualized Family Service Plan (IFSP) which is a service planning process which ideally results in a comprehensive description of the needs and goals of the child and family, and functions as a guide to strategic intervention planning (Moroz & Allen-Meares, 1991). The IFSP differs from the Individualized Education Plan (IEP) in that it goes beyond a child-centred focus and promotes a planning approach which incorporates family priorities and concerns (Boone, Moore, & Coulter, 1995). The purpose of the IFSP is to develop and implement a program to meet the unique needs of not only children, but of their family members who are impacted by the disability (Joanning, Demmitt, Brotherson, & Whiddon, 1994).

The IFSP is a written document which outlines the child and family's strengths and needs, the goals of the child and the family, and designates services needed to reach those goals (Joanning, Demmitt, Brotherson, & Whiddon, 1994). The

IFSP ties together all of the assessment data gathered from various instruments, observations, and informal sources into a comprehensive illustration of the child and family and a guide to strategic intervention planning (Moroz & Allen-Meares, 1991).

Components of the IFSP

Typically the IFSP consists of six elements. These elements include 1) a statement of the child's present level of development, 2) a statement of the family's needs and strengths related to enhancing the child's development, 3) a statement of the major outcomes expected to be achieved for the child and family, 4) a statement of the early intervention services that are needed to meet the needs of the child and family, 5) the projected dates for initiation of the services and expected duration, and 6) the name and signature of the case manager (Bradley, Parette, & VanBiervliet, 1995; Fewell & Snyder, 1991; Moroz & Allan, 1991). A more in-depth description of key components is presented:

Statement of Child's Present Level of Development

An assessment of the child's abilities is generally based on a variety of assessment tools which are conducted previous to the IFSP meeting (Fewell & Snyder, 1991). Campbell (1991) asserts that an ongoing assessment of the child recognizes that young children's needs and abilities are likely to change rapidly, thus assessment tools must be sensitive to change.

The goal of child assessment is to identify functional intervention goals, identify the child's strengths, reinforce the parents' competencies with their child, and to create ownership of all involved parties in the child's life (Bailey, Williamson, Winton, & Simeonsson, 1992). Several studies have indicated that parents can

accurately evaluate their child's current level of abilities (Brown, Thurman, & Pearl, 1993). Thus, parental involvement is essential during the assessment process.

Statement of Family's Needs and Strengths

The purpose of a family assessment within the context of an IFSP is to determine ongoing ways that intervention services may be used to address family concerns and support the strengths of the family (Campbell, 1991). Brown et al. (1993) assert that an assessment of the family's agenda must be emphasized rather than the family itself. Families often indicate preferences for how assessment information is provided and what type of information is shared.

Procedures for assessing family needs and strengths may range from standardized assessment tools to open-ended interviews (Summers & Turnbull, 1990). The IFSP literature supports the use of both structured and non-structured formats (Beckman, 1991; Fewell & Snyder, 1991; Sexton & Snyder, 1991). The least intrusive forms of assessment appear to be relatively informal and give parents the opportunity to complete their own assessments. Minke and Scott (1993) suggest that the purpose of assessments be explained and that parents be given the opportunity to provide their own feedback.

Although a statement of family needs and goals is a vital component of a family-centred IFSP, there is a lack of consensus in the literature regarding the appropriate areas of family life to include (Summers & Turnbull, 1990). Beckman (1991) advised that having a child with a disability does not give the interventionist the right to subject families to time consuming and difficult assessments. Assessing family needs and strengths may be intrusive when areas are centred upon which are not directly related to the child with a disability (Beckman, 1991) and when the evaluation appears to be focused on family members' behavior. Trute, Hiebert-Murphy, and Levine (1999) suggest that interventionists focus on

what families are doing well and encourage the telling of stories, hopes, and dreams. Furthermore, if a family does not recognize a need identified by a service provider, it is not a need for the family and should not be pursued.

Statement of Expected Major Outcomes

Consistent with the family-centred model is the premise that families should be encouraged to identify their own expectations of the IFSP. A statement of outcomes must include the procedures, strategies, and activities, that, if followed, will assist the child or family to achieve a specified outcome (Fewell & Snyder, 1991). Outcome statements generally consist of an identification of both process and outcomes. Thus, global outcome statements are often made with specific activities or plans (Moroz & Allen-Meares, 1991). Notari and Drinkwater (1991) suggest that families identify broad outcomes for their child while professionals provide assistance to develop shorter term goals and to sequence the necessary steps to achieve those outcomes. The development of a smaller number of goals may give the family a sense of greater participation and greater optimism to achieve those goals (Katz & Scarpati, 1995).

The Name of the Case Manager

Another requirement of the IFSP statement is the name and signature of the case manager who will be responsible for the implementation of the plan and coordination with other agencies (Fewell & Snyder, 1991). The service coordinator is typically responsible for assisting with the IFSP process, which includes the assessments of the child and family, and then the development, the implementation, and the monitoring of the IFSP (Notari & Drinkwater, 1991). It is important to note that the development of the IFSP is an ongoing process, which begins when a family enters an early intervention program, and ends when the

family is transitioned to an adult program (Katz & Scarpati, 1995). Thus, the service coordinator is a professional who has ongoing involvement with the family.

Various studies have discussed the implications of various types of clinicians acting as the service coordinator for the IFSP process. Professionals such as nurses, child development specialists, special education teachers and social workers are typical IFSP facilitators. However, several authors have proposed that social work is a logical discipline for providing family-centred early intervention services to families of children with disabilities (Bradley, 1995; Malone et al., 2000).

Social workers typically have knowledge of the systemic nature of families, promote and understand principles of family strength, and understand the need for parent-professional interdisciplinary collaboration (Malone et al., 2000). Joanning and colleagues (1994) suggest that social workers may find that the formulation and implementation of IFSP's may provide an opportunity to provide emotional support to families, and even initiate family therapy. Social workers can assist families to deal with emotions, disappointments, financial concerns, marital interaction, and developmental issues of other children as they relate to the disability (Joanning et al., 1994; Malone et al., 2000).

Dunst, Trivette, and Deal (1992) suggest that the role designated to case managers to implement the plan and coordinate with other agencies is actually in conflict with the philosophies of family-centred practice. The family should in fact, play a lead role in securing needed resources. Thus, the case manager's role may be to empower families with the skills and knowledge necessary to direct their services. Although the assignment of a case manager is seen as an important component of developing effective family plans, the role of the case manager is not necessarily to implement the plan.

Components of a Family-Centred IFSP

The essence of a family-centred approach lies in the relationship that exists between parents and professionals (Bailey, McWilliam, Darkes, Hebbeler, Simeonsson, Spiker, & Wagner, 1998). Parents have indicated that in interacting with professionals they expect a recognition of the family as ultimate decision maker, information and support, and acceptance of cultural and economic diversity (Gallagher & Desimone, 1995).

Role of Professionals and Parents

In order to meet family needs, IFSP's must be developed through a team approach, interagency cooperation, and a partnership between professionals and families (Minke & Scott, 1993). IFSP's that respond to family concerns, resources, and priorities and include equal involvement of parents and professionals are referred to as family driven as opposed to professionally driven (Campbell & Strickland, 1992).

An assessment that is family-centred involves the family members in the assessment of their own child and family (Joanning et al., 1994). Involvement in the process may take various different forms, depending upon the particular family's preferences. Parents may begin the assessment process by identifying the strengths and abilities of their child and indicating what is important to them and their family (Campbell & Strickland, 1992). Although mothers are typically involved in the assessment process, a more family-centred approach is to involve both parents in the process (Joanning et al., 1994). As part of a focus group discussion, parents suggested that professionals pay more attention to the knowledge that parents have about their child, and allow parents to write IFSP goals in their own language (Gallagher & Desimone, 1995).

Parents should be given the opportunity to write their own IFSP (Joanning et al., 1994). Parents who fill out summary forms of child and family strengths, needs, and goals have been found to be more active in the goal-setting process (Minke & Scott, 1993). Katz and Scarpati (1995) found that staff and parents both perceived the role of staff as facilitory and the parents as developing child and family goals. Minke and Scott (1993) recommend that parents are given the option regarding how active they would like to be in developing the IFSP. Some families may be interested in acting as partners with the service coordinator by chairing the IFSP meeting together with the coordinator (Joanning et al., 1994).

Parents can be assisted in various ways to become an integral part of the IFSP process. Campbell and Strickland (1992) found that parents who attended informational workshops on developing IFSP's felt more confident and were more likely to write their own IFSP's. Staff can also teach parents how to answer assessment questions by using words with which parents are more familiar. Instead of asking parents for family strengths, professionals may ask questions like, "What makes you proud about your family?" (Minke & Scott, 1993). Several authors suggests that the initial evaluation should be done by the service coordinator and family initially, and then be presented to the rest of the team later, once rapport has developed between the coordinator and family (Campbell, 1991; Joanning et al., 1994).

Despite holding philosophies of parents as ultimate decision makers, professionals have confessed that it can be difficult to relinquish control, as one's own knowledge and expertise appears to be devalued (Gallagher & Desimone, 1995; Minke & Scott, 1993). Some professionals are unsure of how to assist parents to become more involved, at the same time maintaining the role of professional. Minke and Scott (1993) assert that behavior consistent with the family-centred model includes repeating parent-identified goals, including parents'

comments in the written record, providing parents with copies of all documents, verbally reinforcing parents' skills and contributions, and using verbal and nonverbal cues to elicit parental input. Gallagher and Desimone (1995) suggest that if professionals are viewed as consultants instead of experts, family participation is likely to increase.

Support and Information

The family-centred approach to intervention recognizes that families need to be supported for what they are currently doing with their child, that the importance of decisions that parents make should be emphasized, and that the child's current level of functioning should be related to future accomplishments (Degangi et al., 1994). Degangi and colleagues (1994) also emphasize the importance of providing trust, predictability, and nonjudgmental support to families, rather than emphasizing the need for change.

An important component of the service provider's role is to provide families with information that will assist them to meet the goals they have identified for their child and family. Thus, the service provider must have demonstrated knowledge of the educational, community, and medical resources available to the family (Malone et al., 2000). Heflinger and Bickman (1997) assert that an intervention which provides knowledge, skills, and encourages active participation in decision making facilitates parent empowerment. Gowen, Christy, and Sparling (1993) found that parents express the need particularly to gain information on how to promote the development of their child, support in dealing with the emotional and time demands of parenting, identifying community resources, planning for the child's future, and understanding the child's legal rights.

Acceptance of Diversity

Intervention programs for families who have children with disabilities tend to represent the views of middle class, English speaking, Caucasian families (Beckman, 1991; Degangi et al., 1994). As one's cultural beliefs influence one's approach to childrearing, daily routines, family structure roles, disability and etiology, style of communication, and help-seeking practices, discord may emerge when professionals assume that families represent dominant cultural groups (Degangi et al., 1994).

Cultural competency can be described as a respect for cultural differences and a willingness to accept divergent perceptions about the world (Beckman, 1991). Further, service coordinators who are culturally competent are aware that their own opinions are based upon one's own cultural values, having knowledge of families' values and norms, and demonstrating respect for differing ways of developing family plans. Thus, as part of the assessment process it is vital that professionals learn about the history, belief systems, and patterns of social service utilization so that an understanding is gained of how families' culture effects their communication and participation (Gallagher & Desimone, 1995).

The socioeconomic status of the family must also be considered when identifying family needs and goals. Families who are less educated and impoverished may be more concerned with basic survival and less able to identify the needs of their child than middle class families (Degangi et al., 1994; Johnson, Gallagher, LaMontagne, Jordan, Gallagher, Huntinger, & Karnes, 1994). Kalyanpur and Rao (1991) recommend that the IFSP be responsive to stress that affects the families' basic provision of care by helping families access resources to make home life better.

Rather than viewing cultural differences as deficits, professionals must look for unique family strengths, which may include a supportive extended family or

religious beliefs, and respond to what families express as important, avoiding attempts to educate families about what the service provider feels is important (Bennett, Zhang, & Hojnar, 1998).

Barriers to Effective Implementation of IFSP's

Although the IFSP process is based upon a family-centred philosophy which recognizes parents as experts of their situations and as an integral part of the planning process, the IFSP has been found to be no more effective than other plans when not implemented correctly (Farel et al., 1997). Additionally, parents have expressed a difficulty in understanding the purpose of the IFSP. What is most strongly identified in the literature is the need for comprehensive training for both staff and parents regarding the purpose of IFSP's and information on strategies and techniques to involve parents in the process.

Barriers to developing effective IFSP's may include a lack of staff training, high case loads and other job responsibilities, decreasing budgets, scheduling difficulties with parents and various service providers, and a lack of complete information from parents (Farel et al., 1997; Gallagher & Desimone, 1995). The lack of training and time to develop practical and useful IFSP's may result in a lack of significant parent involvement, missing data, poorly written goals and objectives, unclear links between assessments, goals, programs, and evaluations, and a lack of monitoring (Gallagher & Desimone, 1995). Farel and colleagues (1997) found that when service providers did not perceive the IFSP process as useful, the potential impacts upon children and families were reduced.

Professionals may make the assumption that families are incapable of making decisions when they first enter an early intervention program due to parents often being in early stages of adjustment to their child's disability. These reservations may result in a tendency to allow families to depend too much upon professionals

(Minke & Scott, 1995). These assumptions may result in a lack of information sharing and in a lack of consideration for family-developed goals (Katz & Scarpati, 1995). Degangi and colleagues (1994) found that only 50% of a sample of service coordinators considered family values and preferences when developing IFSP goals. Despite various agency and professional claims to hold family-centred values, staff tend to have concerns about whether all parents possess the skills to effectively participate in the IFSP process (Minke & Scott, 1995). Staff may also view qualities such as parental assertiveness and high family control as threatening when these same qualities reflect the potential for a family-centered focus (Minke & Scott, 1995).

Additional barriers to parent involvement may include rigid use of assessment tools, lack of family interest, skills, or resources, lack of parent training, and professionals' tendency to preserve a child-focused approach (Katz & Scarpati, 1995). The IFSP process continues to be viewed by both staff and families as child-focused, as the facilitation of child development continues to be the primary focus of the process (Katz & Scarpati, 1995).

Gallagher and Desimone (1995) propose that in order for IFSP's to reflect family-centered values, both professionals and parents should receive training, which may occur in the form of an orientation for parents and a workshop for professionals. Experienced parents can often be effective leaders of parent orientations (Campbell & Strickland, 1992). Some researchers assert that staff require more time to work with each family so that each part of the process is given ample attention, including reviews and updates every six months (Gallagher & Desimone, 1995).

Most of the information available on the development of IFSP's recommends procedures and practices to assist in guiding the development of the IFSP process. However, there are very few empirical studies available which provide

data on preferred practices, techniques, and expectations (Gallagher & Desimone, 1995). Furthermore, little research is available regarding the challenges of defining professional and parental roles, particularly related to culturally diverse families (Degangi et al., 1994). Clearly, there is a need for greater research in the area so that IFSP's can be developed which respond to the needs of families, which is the premise of family-centred practice.

CHAPTER THREE

INTERVENTION

Recruitment of Participants

This practicum was carried out as a component of the Family Strengths in Childhood Disability (FSCD) Project, which is a Manitoba study which is assessing the implementation of family-centred services to families who live with a child with a developmental disability. Family service workers (FSW) selected practicum families following a presentation by the student outlining the purpose, goals, and components of the practicum. Families who were approached had entered the service system prior to 1999 (were not already participating in the FSCD Project), had not previously developed an IFSP with their FSW, and were chosen based upon the FSW's perception that they would both benefit from and consent to participate in the practicum.

Families were contacted by their FSW who provided a preliminary explanation of the practicum, and inquired as to whether the family would be interested in either meeting or speaking with the student to discuss the practicum process and their potential involvement. Once the FSW had received verbal consent to participate, or at least to receive further information from the student regarding the nature of the practicum, the FSW contacted the student and provided some basic information about the family and child. Prior to participating, families provided written consent to participate in the practicum, and were given the opportunity to advise as to whether they consented to having the final IFSP document added to their case file (see the appendix for a copy of the consent form). Families were

given the choice of meeting in their home or in another environment that was suitable to them. Families were given the option of being reimbursed for baby-sitting and/or parking expenses.

Design

This student met with 9 families, which included various family forms, including single, two-parent, and blended families. Each family participated for an average of 6 hours which took place during two to five sessions. The purpose of the practicum was explained prior to participation, and families indicated whether they would like to proceed. None of the families who were approached refused to participate, however, two families had only one parent/caregiver participate due to scheduling difficulties and/or lack of interest.

The purpose of having the FSW present was to both recognize the knowledge that case managers bring about families and community resources, as well as to provide consultation regarding the development of IFSP's. The IFSP process consisted of three components, which included rapport building, assessment of child and family strengths and needs, and the development of the IFSP. This student encouraged the FSW's to attend each session, however, only five of the FSW's attended all sessions, two attended three out of four sessions, and two attended half of the sessions. Each FSW attended the session which focused around the development of the IFSP. Although consultation to FSW's was one goal of the practicum, various factors contributed to the lack of full participation.

Rapport Building

Developing rapport with families is ongoing, however the first portion of the initial meetings was centred around joining with the family by explaining the philosophy and purpose of the practicum and giving the parents the opportunity to

share information about their child and/or family. The student explained the goals of the practicum (emphasizing the desire to understand families' preferences regarding providing information and receiving services) and outlined the various components involved, ensuring that parents had the opportunity to look at the assessment measures, summary forms, and IFSP document. Parents were advised of the philosophy under which the student was operating, and discussion regarding components of family-centred practice typically ensued.

The student attempted to allow the conversation to be parent-directed in that specific information was not initially sought out, rather the student was attentive and strengths focused. The purpose of this approach was to assure the family that their behavior was not being critiqued, but rather that the issues pertinent to them would direct service planning. In addition, the student was attempting to determine how to proceed with the assessment component, by observing factors such as parental trust, communication patterns, and parents' ability to articulate their needs. These factors tended to influence the sequencing of gathering information, the types of questions asked, and the areas of focus. The student did not proceed with actual assessment procedures until the consent form was signed and the student was assured that the family had a basic understanding of the process.

Assessment of Child and Family Needs and Strengths

An assessment was carried out utilizing both open-ended questions and the standardized assessment measures that were compiled for the FSCD study. Areas of assessment included the strengths and needs of the child with a disability, the strengths and needs of specific family members and the family as a whole, and the resources and supports that the family currently had access to or required in order to get needs met. The assessment sessions were all organized

based upon these three areas, however, overlap into various topics often occurred throughout the information-gathering process.

Assessment of child characteristics included information such as the child's developmental level (cognitive, physical, language and speech, psychosocial, self-help skills), the nature of the disability, health and medical needs, equipment needs, preferred activities, participation in community, contributions to the family, impact on routines, sibling relationships, and the family's hopes for the child in the next 6-12 months. Family areas which were typically explored included information on family structure (who is part of the family, socioeconomic status and educational and vocational backgrounds, role assignment, culturally-based beliefs, general attitude towards disability), and areas of family functioning (impact of disability on family relationships, intrusions into the home, financial and social restrictions, decision-making processes, coping strategies, communication, approach to future planning, parental stress, strengths of family). Assessment of family supports and resources included an exploration of current informal and formal support networks available to the family, the perceived helpfulness of these supports in various areas, potential but currently untapped sources of support, the ideal support system of the family, and current service and resource needs of the family.

Family assessment measures used included the Family Needs Survey (Bailey & Simeonsson, 1988), Information on Children in Family with a Disability form, Family Support Scale (Dunst et al., 1988), Family Implications of Childhood Disability Scale (Trute & Hiebert-Murphy, 1999), Brief Family Assessment Measure III (Skinner, Steinhauer, & Santa-Barbara, 1984), Family Functioning Style Scale (Dunst et al., 1988), Parent Self View (Rosenberg, 1965), Daily Feelings Scale, Social Network Inventory, Grandparent Support Index, Parenting

Stress Index, and a socio-demographic Form*. The student attempted to draw upon all of the assessment measures, however the student encouraged the family to direct the process, which sometimes resulted in the exclusion of particular measures and a greater emphasis on the interview or open-ended component of the assessment.

The student utilized the measures as tools for facilitating an increased atmosphere of sharing and parental control over the process. As parents indicated answers that demonstrated particular strength or need in a given area, the student commented on the responses, giving the parent an opportunity to elaborate and to indicate whether that issue was one which they wanted to address during the planning process. Depending upon how much information was generated during the discussion of responses to the measures, the use of interviews was either amalgamated into the use of the measures, or the interview took place following the completion of the measures.

Family interviews were initially conducted in a structured format, in which the student asked predetermined questions to the family in a particular sequence. The student refereed to various family assessment literature and an IFSP handbook (Turbiville, Lee, Turnbull, & Murphy, 1993) to guide the interview. As the practicum proceeded, however, the student became more flexible regarding the way questions were framed and the order in which questions were asked. The student attempted to ask questions in ways that did not reflect professional jargon. For example, instead of asking families which early intervention services they required, families were asked what they would like to see for their child in the next 6-12 months. Reframing techniques were also used when parents identified

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*For more information contact Dr. B. Trute, Principle Investigator, in the Faculty of Social Work at the University of Manitoba, or visit www.familystrengths.ca

areas of need which may be viewed as potential strengths. Techniques such as an adaptation of an ecomap or genogram were used if families appeared to need assistance to identify family resources.

Developing the IFSP

The development of the IFSP occurred once both needs and strengths had been identified, and the family was ready to develop a plan to address their expected outcomes. The family was encouraged to invite whomever they felt may contribute to the planning process, in addition to the student and FSW.

In order to ensure that important themes were noted, and to increase parent-direction and empowerment, the student summarized both the strengths and needs that were identified by the parents or student during the assessment process. Each member of the process was presented with a written summary of strengths of the child and the family that were evident during the assessment process (e.g. the families' reliance on support network, parenting skills, positive areas of family functioning, positive qualities of child). This summary was used to structure the IFSP session. Additionally, the student ensured that, regardless of the magnitude of needs identified during the assessment phase, that a larger number of strengths were identified on the summary sheet, and that the strengths were emphasized before discussion centred upon identified needs.

Following an emphasis on family strengths, the student asked the family whether the needs that had been summarized accurately reflected the information that was shared during the assessment process. The parents were then asked to prioritize the needs that had been identified in order to ensure that the needs that were addressed during the planning meeting were the ones that the parents felt needed to be immediately addressed.

Expected outcomes were generated based upon the needs that families had identified. The IFSP team framed identified needs into expected outcomes, and the student and FSW assisted the families to develop action plans intended to meet expressed needs. A variety of service providers as well as family members were identified as responsible for carrying out responsibilities to meet expected outcomes. These plans were recorded on an IFSP document along with projected dates for initiation and completion of services.

The family and FSW were provided with a copy of the completed IFSP document in order to guide their work together. The student kept each IFSP and related documents on file until the completion of the practicum and then shredded all documents which held identifying information. It was clearly emphasized that the FSW's role was to assist in the implementation of plans, and that the student's involvement was for the purpose of both developing skills in the IFSP process and providing consultation to the FSW's. The student was, however, identified as a resource on some IFSP documents and was involved in some action plans by providing the family with relevant information.

Recording Procedures

Extensive recording procedures were implemented throughout the practicum. The various worksheets which were used throughout the sessions (completed measures, information summary sheets, completed IFSP sheets) held important information for both supervision purposes, and to summarize and analyze findings. The student also recorded pertinent observations following each session in a log book. The student organized information into various areas, which included discussion about the IFSP process (e.g., approaches to assessment, sequencing of entire process), families' interaction with the IFSP (particular type of issues which lend itself to the IFSP, how partnership may emerge with families),

the students' observations regarding FSW characteristics, training implications, and the student's observations regarding personal skill development. Families provided their consent to have the sessions audiotaped which was intended as a learning tool for the student, as a potential staff training tool, and as a facilitator for the supervision process. The student audiotaped some sessions, however, session dynamics were difficult to capture on tape, as a large degree of the student's time with families was spent filling out measures and discussing needs informally. Other barriers to audiotaping sessions included the discomfort of some families in being taped and the inappropriateness of videotaping in public meeting places, such as coffee shops.

Evaluation

The student's performance was evaluated by the advisory committee in several ways. The student received consultation from committee members through direct meetings, telephone, and e-mail. The primary advisor based adequacy of performance upon the review of IFSP documents and log notes throughout the practicum. The advisory committee met upon the completion of the practicum to ensure that sufficient hours were completed and that the student had received a variety of experiences related to the development of IFSP's. The committee also evaluated the student's final report.

The student evaluated her experience through the analysis of whether educational goals were achieved. The student also provided recommendations for future practice, research, and training based upon her practicum experience.

The FSW's who participated in the practicum completed feedback surveys which outlined their understanding of the IFSP process as a result of their participation, the components they found most valuable, and their recommendations for caution in the collection and use of IFSP information.

CHAPTER FOUR

PRACTICUM FINDINGS

The student focused on several areas of analysis throughout the practicum. The first level of analysis involved the gathering and organization of assessment data from the families who participated. The student gained a large degree of information from families regarding child characteristics, family structure, typical child and family strengths and needs, and actual and needed supports and resources. However, the second area of analysis went beyond the actual information provided to an analysis of the families' response to various aspects of the IFSP process. The student was particularly interested in families' preferences regarding relationships with professionals, their role in the IFSP process, their preferences in providing information, and their responses to developing family plans. The third level of analysis involved the Family Service Worker's (FSW's) responses to the process. The student was interested in how FSW's viewed their roles with families and how they responded to the IFSP model of service. The involvement of FSW's in the practicum also allowed the student to make some observations about implications for staff training methods. The findings are presented based upon these three areas of analysis.

Information Gathered from Families

As stated, a comprehensive assessment includes gathering information about characteristics of children and families and child and family strengths and needs.

Family Structure

Nine families participated in the practicum. Three married couples participated as well as a woman living in a common-law relationship. One of the married couples was a recently blended family. Five single parents participated; four of them were single mothers, and one was a single father. Two of the single parents were recently separated, one mother was divorced, and two of the parents were widowed. All of the fathers who participated were employed, except for one. All four had achieved at least grade 12. Two fathers had achieved degrees, one at a vocational college and the other at a university. Five of the mothers who participated were not working; two were unemployed and seeking work and three were homemakers. One mother worked full-time, another was self-employed, and one mother worked part-time. All of the mothers who participated had achieved a grade 12 education, and two of them had achieved a 2-year vocational program. The families had an average of 2.3 children. The average age of the child who had been diagnosed with a disability was 7.9 years. Although not all of the families indicated a family income, it appeared that most of the families were low to middle income earners.

Nature of Child Disability

The most common disabilities that characterized the children of the families who participated in the practicum included developmental delay and ADHD, sometimes concordantly. One child was diagnosed with Down's Syndrome, another with Fetal Alcohol Effects, and two had characteristics of Autism. Very few physical disabilities were identified, other than minor hearing loss, speech difficulties, and fine motor delay.

Typical Child Strengths

Most families very readily identified a variety of qualities about their children which were perceived as strengths. The most common qualities that were reported included a tendency to be social, sensitive, happy, determined, well-mannered, independent, and thoughtful. Most parents were able to frame qualities positively that were also seen as challenging. For example, one family described their child as dramatic, charismatic, and full of energy. Although these characteristics contributed to stress in the home, the parents readily recognized the potential for their child to use these qualities in a positive way.

Families were also able to identify various positive impacts that the child has had upon the family. Most families asserted that their child had contributed to personal growth, taught them what is important in life, and made life more meaningful for family members. Families also identified various ways in which their child had contributed to their lives, indicating that their children keep the family happy and enthusiastic, facilitate tolerance and patience, keep the family involved in the community, facilitate parental communication, encourage the family to stay active and social, simplify life, and help the family to slow down. Families tended to emphasize the positive qualities of their children to a far greater degree than the difficulties.

Typical Family Strengths

Far more strengths were identified in families than needs and concerns. This finding was consistent with literature which asserts that despite these families' tendency to experience greater stressors than families with typical children, families who have children with disabilities tend to exhibit a variety of strengths

(Wikler et al., 1983). Families both reported and were observed to have various strengths in areas of family functioning, parenting skills, and coping techniques.

Families who participated in the practicum typically described their ability to function as comparable to other families. Although families experienced some additional stressors due to frequent health care appointments and involvement with a large number of service providers, families typically did not perceive these stressors as impacting upon their ability to function well. Several families found that their child's qualities facilitated positive functioning in some areas. For example, several families indicated that their child's social and high-energy personalities provided them with a larger degree of social opportunities than they may have had otherwise. Families also tended to view their routines as just a natural part of their lives, rather than viewing child needs as impacting negatively upon their schedules and every-day functioning. These families had their own unique routines and traditions like other families. Most families reported effective communication, problem-solving, and conflict-resolution skills, reported close and caring relationships, and described a large number of activities that family members enjoyed together. Difficulties that families experienced in every-day functioning were often always attributed directly to child characteristics and needs.

When positive qualities were identified in children, an opportunity was often provided to emphasize parental strengths. Child qualities such as good manners and assistance with household chores were often attributed to effective parenting skills. The student also observed a variety of positive parental qualities including creative teaching and stimulation, recognition of child cues, flexibility and ability to match the pace of the child, consistency in disciplining and child consequences, provision of a safe and structured home, ability to organize and plan ahead, and the ability to ensure their child's needs were met.

Families who participated reported a variety of ways through which they coped with stresses of care giving. Coping mechanisms involved adaptive appraisals of one's situation, active problem-solving, and reliance on social supports. Examples of adaptive appraisal involved emphasizing child and family strengths, recognizing small accomplishments, appreciation for unique qualities of family members, optimism about the future, reliance on religious beliefs, and an ability to perceive all families as unique. Parents also shared a variety of methods in which they actively coped with stress, primarily by taking time for their own individual needs, developing regular family routines, planning ahead, developing assertiveness and advocacy skills, reliance on humour and relationships, and involvement in activities and careers that are enjoyable and meaningful. Receiving supports from informal and formal networks were also described as ways in which families were able to cope with daily stress. Families reported that utilizing physical, emotional, and financial support from social supports, sharing activities with friends and family, utilizing respite, and accessing various services and resources were effective ways of coping.

Defining Needs

As the term "needs" is a broad concept which is used to define a variety of activities, events, or goals that are viewed as important to an individual, families framed their needs in a variety of ways. Some families defined needs very generally, indicating that they desired to be better parents or that they wished for their child to be more independent. Other families defined needs very concretely, asserting that they would like an adapted bike for their child or transportation for their child to daycare. Needs were also framed in terms of what kinds of services and resources families wanted access to. The student found that it was helpful to discuss what the actual desired outcome was for families (e.g., for the child to eat

more independently) and then to determine what was required in order for that outcome to be achieved (e.g., referral to occupational therapist for adapted utensils). The role of the student was often to assist families to break down broad needs into more specific, workable goals.

Typical Child Needs

As each family had been involved with the service system for at least two years, it was apparent that a lot of their initial needs and concerns related to their child had been addressed. However, common concerns that were identified related to developmental and social needs, and access to medical, educational, and community services. Parents provided information related to physical, cognitive, communication, social, and personal care abilities and needs. Services that were the most commonly required were behavioral specialists, child development counsellors, physiotherapists, speech and language pathologists, and adaptive equipment.

Typical Family Needs

The student found that most of the needs reported during the practicum were either family needs that were related to the child's disability (advice and support from parents who had children with similar needs) or family needs that were not necessarily related to the child's disability. Thus, families were more apt to discuss family needs than direct child needs throughout the practicum sessions. This finding was not consistent with claims that families tend to want to focus primarily on their child.

Families identified a variety of concerns related to their child's developmental needs and access to related programs and services. The most common need expressed by families related to their child was the need for information about the

child's diagnosis and services which would facilitate development and healthy functioning. Desired services included behavior management, child development, educational programs, health care services, social activities, and adaptive equipment. Parents wanted greater information about the service system and their role in accessing services. For example, families were often unclear about whether they needed a referral to a service, or whether they could make contact directly. Parents were often unsure what their options were in gaining child-related supports, how services connected with each other, and whether particular services were funded. Families demonstrated an ability to direct services for their children when they understood how the system operated.

Several of the needs expressed by parents were related to the desire to have a more active role in their child's services. For example, one family expressed the desire to receive self-administered respite dollars so that they could manage their own respite schedule and staff. Several other families shared a desire to be more actively involved in their child's school or day care program. One parent advised that she wanted her son's program to focus largely on personal care skills, however, she did not know if it was appropriate for her to schedule a meeting to discuss her concerns.

Parents also reported a variety of personal needs which resulted from stresses of care giving, including respite, a desire to meet other parents who they connected with, more personal time individually or with their spouse, assistance in gaining more support from family members and friends, and knowing how to explain their child's needs to others. Some parents felt somewhat trapped in their role as a parent and were interested in pursuing some relationships, activities, and employment opportunities. A few parents expressed a low level of self-esteem and emotional issues that they felt needed to be resolved.

Families also tended to share needs of their entire family which were not directly related to having a child with a disability. These families often experienced barriers to achieving basic employment, financial, household management, and recreational needs, which were often exacerbated by child care responsibilities. Needs of siblings were also discussed by a few families.

Families' Response to the IFSP Process

The Joining Process

The student found that joining with families typically occurred during the first session, often within the first 15 minutes of arrival. When the student first arrived, families were usually welcoming but cautious. The student immediately thanked the family for their willingness to participate and to allow the student to visit their home. It became evident that families are more willing to share and participate when professionals express appreciation and respect for their time. The student also discovered that the joining process was facilitated by the taking an interest in family members and their home. The student asked questions about family pictures, took an interest in the apparent interests of family members, and immediately looked for strengths in family interactions and routines. Although this approach may appear to be somewhat intrusive, the student was always cautious in reading parental cues and avoiding comments which may be interpreted as being critical or judgmental (e.g., commenting on the cleanliness of the home).

Although the student was observant about the home environment, care was taken to encourage the parents to direct conversation. This was achieved by making a comment or asking a question, and then taking an interest in the response of the parent. The student found that when questions and comments were framed positively, the parents were more apt to share information about

strengths and needs, as trust was already developing. An effective way of joining with families, at the same time, initiating the assessment phase of intervention, was encouraging families to describe the child's abilities and to demonstrate the child's strengths. Asking parents to begin the assessment process in this manner was both strengths-focused, and set the stage for parental leadership throughout the process.

The Role of Professionals and Parents

The student made ongoing efforts to facilitate a partnership model with each family who participated in the practicum. The student was aware that, although family-centred practice emphasizes a parent-directed process, each family will respond differently regarding their role preferences. Additionally, families are not accustomed to playing a leadership role in developing services, and tend to expect professionals to take the lead. The student identified various approaches to facilitating greater parental involvement in the IFSP process. These approaches involved the explanation of the family-centred philosophy, the explanation of the IFSP process, the facilitation of parent-identified goals, the summarizing of assessment information, and the facilitation of parent-directed family plans.

Explanation of the Family-Centred Philosophy

The initial practicum sessions began with an explanation of the purpose of the practicum and the philosophy behind the implementation of IFSP's with families. The student explained that a family-centred approach emphasizes the strengths of families, the knowledge that families have of their own children and family, the abilities of families to direct their own services, and the need for services to extend beyond the child to family members who may be impacted by the disability.

Practicum families displayed a larger interest in participating once they were aware that their priorities and concerns, rather than those of the student, would be the focus of the practicum. This approach was particularly effective for families who had had negative experiences with service providers in the past which had resulted in a tendency for them to mistrust professionals. One parent indicated to the student that had it not been emphasized that the parents were the leaders of the process, he would not have agreed to participate. Emphasizing that families are the real experts of their children was also an effective way of facilitating parental involvement. Some parents explained various characteristics of their child's disability to the student, embracing an educative role. It is vital that case managers explain the philosophy by which the IFSP is guided so that families are empowered to actively participate early on. The roles that are established between parents and their case manager at the early stages of intervention will likely set the pace for future interaction patterns.

Explanation of IFSP Process

An explanation of the IFSP process is also a vital component to facilitating early parental participation. Parents are not likely to develop a partnership with professionals if they are unclear about what is involved in the process. The student explained the various areas that are typically explored during assessment and showed parents some of the measures. One of the fathers that participated chose to keep the measures with him prior to the assessment session so that he could review them and anticipate his responses. The student also showed families summary sheets and IFSP documents and explained how these forms were used throughout the process. Although an explanation of the process appeared to assist most parents to more actively participate, it was evident that many parents were not accustomed to playing an active role in developing their

services. One parent did not initiate any discussion unless asked questions. Even when asked questions, she tentatively answered as if she may be answering incorrectly. It was apparent that her experiences with professionals in the past had taught her that her role was as an observer. After two sessions and repeated emphasis of the purpose of the IFSP process, the parent began embracing the plan as her own.

Facilitation of Parent-identified Goals

It is common for case managers to identify what they perceive as needs for families and to encourage families to embrace the agenda set out by professionals. However, the principles of a family-centred approach to service emphasize that families should identify what they perceive as needs, and not be pressured to address areas that are not of concern to them. The student noticed that when families were encouraged by their FSW to access services that they did not want, they were less likely to initiate discussion with their case manager about other potential areas of need. The student was able to use both the informal interviews and standardized measures to assist families to identify their concerns and priorities in a way that was parent-directed.

Families responded very openly to being asked what they want for their child and family, and what kinds of supports would be most helpful to them. It appears that too often, case managers tend to make observations and then make recommendations without asking families what they feel is a need for their family. Questions such as "What would you like to see for your child in the next 6-12 months?" and "What are your immediate needs as a family?" were found to be simple ways of determining what the priorities were for families. More specific questions also assisted parents and professionals to develop goals which were based on parent-identified needs. For example, asking one family how their child

impacts upon daily routines initiated discussion regarding the parents' inability to spend time together as a couple. The parent then identified that personal time as a couple was a need for them in order to function as effective parents.

Standardized measures also assist families to identify their own goals. One family indicated on the Family Support Scale that only professionals were perceived as helpful and that friends and family were not supportive. The parent and case manager then discussed why the parent felt that these sources of potential informal supports were not available. The parent indicated that she did not know how to ask for support, and would like assistance in learning how to communicate better with family and friends. The case manager plays a large role in assisting in the identification of needs by asking the right questions, but the family should be the ones who identify the actual need.

There were instances when the student noted potential needs for families, but was sensitive in the way that the needs were addressed. One father had identified that he had a distant relationship with his son while completing the Parenting Stress Index. The student asked questions such as, "What are your hopes regarding your relationship with your son?" and "What do you think needs to happen in order to develop that desired relationship?". The father admitted that he would need to seek individual counselling in order to resolve his inability to trust others, however, he was not ready or willing to take this step. The student did not pursue this matter, but affirmed that the father knew what to do when he was ready. During the IFSP session, the father noted that he would like to address his need for counselling so that he could become closer to his son. Although the student had believed that counselling was important for this parent, the student allowed the parent to come to this realization on his own by asking the right questions, and then not pressuring him to take action.

Summarizing Assessment Results

One difficulty that case managers express in developing IFSP's with families is translating expressed needs during assessment into a comprehensive family plan. The student found that the development of a summary sheet, outlining family and child strengths and needs, was an effective tool for organizing the development of the IFSP (see the appendix for an example of a summary sheet). In addition to providing a structure for the planning session, utilization of the summary sheet was also effective in emphasizing child and family strengths and promoting a family-directed planning process.

Providing each team member with a summary sheet of the identified strengths and needs was an effective way of ensuring that each member was able to follow the IFSP process. Summarizing the results of the assessment assisted the family, student, and FSW to recall the primary themes that were identified during the child and family assessment. Providing a summary was also helpful for team members who were not present during the assessment. It is not necessarily appropriate for a multi-disciplinary team to conduct an initial child and family assessment together, thus, the family and case manager can present a summary of information at the IFSP meeting.

Families responded very positively to being presented with a list of child and family strengths. The student listed various strengths that were identified by the family during the assessment and through observation of family functioning and interaction styles. Many of the strengths that were identified by the student had not been framed as strengths by the family, but were perceived by the student as positive. Even some areas that were described as needs by the family were reframed into areas of potential strength. For example, one mother perceived her tendency to worry about her child as an area in which she required some support.

Although the student and FSW affirmed her concern, the student also listed her tendency to worry as a strength, as this quality really demonstrated her love for her child and her desire to be a good parent.

The emphasis on strengths also facilitated an atmosphere of openness and a larger degree of comfort for families to discuss family concerns and experiences. Once the student had emphasized the strengths that had been identified, and the focus had turned to family needs, families tended to view their needs as less overwhelming and appeared more open to discuss their concerns than earlier on in the process. One family in particular began opening up about their initial reaction to their child's diagnosis following the discussion about family strengths, which was an area of discussion that had not arisen during the assessment portion. This family had presented as somewhat defensive about discussing needs in previous sessions, but appeared to be empowered by the strengths-focus.

Presenting families with a summary of the assessment information also contributed to a family-directed process in developing IFSP's. The student gave families the opportunity to express whether the student's analysis of their strengths and needs were consistent with their own perceptions of their situation. The student also emphasized that each family had indicated a larger number of strengths than needs. The family then had the opportunity to decide how to proceed with the IFSP session by prioritizing each need that had been identified. Some families gave each item a priority number. Other families chose the top two or three needs which they felt they would like to address at the meeting. This practice ensured that family priorities were addressed. It was common for only a few needs to be addressed at IFSP sessions, as some needs consisted of various components, and developing plans of actions for several plans was seen as too overwhelming for families.

Facilitation of Parent-Directed Family Plans

The student attempted to enlist parents to participate in all aspects of the IFSP process. Once the parents had prioritized the needs which they wanted to address, the student assisted in the wording of the expected outcomes and action plans. The student found that parents usually took the lead in articulating the actual desired goals, and that the student and case manager presented various potential plans of action to reach stated goals. Parents usually generally knew what they needed in order to achieve their goals, however, often, parents expressed feeling uncertain in proceeding unless they felt that professionals were collaboratively working together with them. Furthermore, several parents expressed a greater sense of initiative to pursue goals when an action plan was in front of them which they could refer to individually and with their case manager. Parents are often overwhelmed after meeting with professionals and may have difficulty remembering what they have agreed to do. Furthermore, parents seemed relieved that the responsibility of case managers was indicated on the plans, perhaps as an insurance of accountability.

Although parents were very involved in the planning sessions, none of the parents were interested in actually writing out the plan themselves. The student wrote out eight plans, and one FSW decided to write out a plan (see the Appendix for an example of an IFSP). The parents did not seem particularly interested in how expected outcomes and action plans were worded, however, they expressed a preference for parent-friendly language. For example, instead of writing that a child "requires more age-appropriate peer interaction opportunities in order to facilitate social skills development", parents preferred to see outcome statements such as, "Jane will go to preschool two mornings per week so that she has the

chance to play with children her age who can stimulate her learning and development".

When professionals express skepticism around the utilization of IFSP's with families, the primary concern appears to centre around the anticipated increase in time required to implement family plans. However, professionals must keep in mind that the actual implementation of the plan should also utilize a partnership model. Although the initial amount of time spent with families may increase due to a more in-depth child and family assessment, the goal of family-centred practice is to assist parents to gain the knowledge and skills to direct their own services. Thus, over time the case manager will spend increasingly less time initiating services and supports.

The student found that the parents were identified as responsible for following through on action plans to at least the same degree as were case managers. Case managers were often designated to provide information or to make a referral to a particular service. Parents were typically responsible for contacting service providers and other supports and filling out forms/gathering needed information to receive a particular service. The case manager's role was typically quite brief, and often secondary to the parents'. For example, one parent wanted her son with autism to become more independent in areas of personal care. The team agreed that a school meeting with her son's resource teacher, teacher's aid, and occupational therapist was required in order to implement some programming that addressed personal care. The parent was responsible for setting up the meeting, and the FSW agreed to attend and provide support as needed.

The Importance of Comprehensive Assessment

The student's experience in conducting in-depth assessments with families confirmed that a comprehensive assessment of child and family needs and

strengths is a vital component of the family-centred approach to practice. Throughout the practicum, it became increasingly apparent that the process of identifying the strengths and needs of families and their children is in fact the most important part of the IFSP process for some families. Some families required some assistance in articulating their needs, however, once their strengths were emphasized and priorities were clarified, the actual implementation of a family plan was quite straightforward.

The student recognized that issues related to assessment with which case managers tend to struggle will typically include sequencing the assessment process, the benefits of standardized measures, and the appropriateness of gathering particular types of information from various family structures.

Sequencing the Assessment

The student had initially developed a sequence for collecting information which involved the use of measures in a particular order, and then an interview which would again be quite structured and sequenced. The student increasingly recognized during the assessments that in order to gather information that was relevant to the family, and to instill an atmosphere of family strength and control, it was important to spend time listening to the direction of the family rather than imposing an agenda upon the process. As each family responded to assessment differently, the student began to learn to more accurately read parental cues as the practicum progressed.

The student found that it was usually appropriate to base family assessments around the use of either the standardized measures or family interviews. When an assessment is done primarily based upon the utilization of measures, sharing of information will stem from the discussion of measure responses. However,

families who demonstrate a preference for sharing information verbally, may participate in an interview with measures drawn in as appropriate.

Some families initiated service contact due to a particular need (e.g., child development counsellor). These families were quite clear about their service needs, and required little prompting regarding various areas of child and family issues. Older families who had been receiving services for several years and were not accustomed to completing standardized assessment measures also responded more positively to sharing information verbally.

When families clearly verbalize their needs, gathering information through the use of an informal interview will typically be the most appropriate. However, organizing the assessment around the standardized measures was found to be most effective when families were unsure of how to articulate their needs, were unsure of the services available to them, and would evidently benefit from various forms of intervention.

Positive Responses to Standardized Measures

The use of standardized measures has been critiqued as creating an environment which is too formal, intrusive, and assumes deficit. However, the use of measures in gathering information was found to prompt the retrieval of important information, to facilitate more in-depth discussion, and to identify various child and family strengths.

When asked how they felt about providing information through use of the measures, most parents responded that filling out the forms was helpful in retrieving information that is important to addressing their needs that they may not have thought about otherwise. Completing the measures appeared to have triggered the release of a large amount of information for parents, resulting in an increased comfort in discussing child and family issues than previous to the use of

measures. Drawing upon measures tended to be an effective way of developing rapport with families.

Furthermore, families sometimes have difficulty articulating their needs, particularly when they are overwhelmed by a confusing system and professional jargon, and feel more comfortable in referring to a need by pointing it out on paper. One mother did not feel that she had adequate abilities as a parent, but was not comfortable in discussing this until she identified on the Family Needs Survey that she would like to learn how to handle her child's behavior more effectively. A discussion then ensued regarding her options in being referred to a Behavioral Specialist or Parent Aid.

In addition, the measures provided information to parents about what kind of services are available to them. Parents noted that various service options, such as connecting with other parents, future planning, being referred to a psychologist, and receiving self-administered respite, were needs for their family, however, they had not been clear as to whether their FSW could assist them in those areas. Families are often unclear about service providers' roles and scope of services, and are not always comfortable in initiating discussion in those areas. One parent advised that she would have appreciated filling out the measures (particularly Family Needs Survey, Parenting Stress Index, and Family Implications of Childhood Disability Scale) when she first became open to the service system.

In addition to prompting the retrieval of relevant information, the use of standardized measures can actually be viewed as less intrusive than verbally asking families questions about families' concerns and needs. Families were given the choice of having the questions read out loud or in filling the forms out independently. When families filled the forms out independently, the student noted when particular needs or strengths were identified. Usually the parent would elaborate on their responses without prompts. When they did not

elaborate, the student then either prompted for more in-depth information or asked the parent whether that was an area that they would like to explore in the context of their services from their FSW. When parents provided further information and indicated that this was an area that was important for them to explore, that area was noted as an area to discuss during the IFSP session. When parents did not elaborate or respond to prompts regarding identified areas of need, the student did not apply pressure for greater discussion.

The student ensured that families were always asked whether they would like to complete the measures independently or have the student read out the questions and/or fill in the answers. Some families were intimidated by the language on the forms, displaying difficulty with reading and comprehension. In one case, English was a second language. The student offered to read the questions out loud, which provided the opportunity for the student to reframe the statement if needed, and to enter into discussion about the statement with the parent.

Although the student only had the opportunity to meet with three two-parent families, the student readily recognized that couples may benefit from filling out standardized measures as a team. When both parents participated in the practicum, they were given the choice of filling out their own set of measures or filling them out together. Each two-parent family chose to fill out the forms together, demonstrating a curiosity regarding the perceptions of their partner, and a desire to develop goals as a family, rather than individually. Each family expressed having benefited from the experience, stating that the exercise assisted them to work together and to understand each other's experience of their family life. This approach to gaining information facilitated a greater degree of dialogue and gave the couples an opportunity to share their feelings in a non-threatening environment. The student heard comments such as, "I never realized that you felt that way", or "I know you are comfortable in this area but this

is something I need help with". The experience also allowed for couples to share with each other their perceptions of what was going well in their family.

Utilization of the standardized measures generally assisted the student to approach the family in a strengths-based manner. Several of the measures ask questions about what is working in families. The Family Implications of Childhood Disability Scale asks the family if they have grown as a result of the experience, and come to terms with what should be valued in life. The Family Functioning Scale asks the family about cohesiveness and communication. Although the measures identified various forms of needs, they equally identified that families were generally coping well, and had established family routines and functioning that were typical of other families. The experience of being able to indicate responses to various measures which identified greater strength than need was evidently empowering for some families.

Based upon the utilization of standardized measures with practicum families, the student has determined that this approach to assessment can actually facilitate a family-directed process. The use of measures can be an effective way of providing information to families regarding available services, and can unintrusively prompt families to elaborate on areas that are important to them. Furthermore, the use of assessment measures can actually facilitate informal discussion, as opposed to hindering effective communication.

Responses to Specific Standardized Measures

The student utilized up to twelve standardized measures throughout the assessment of the nine families that participated. Certain forms were found to be useful by every family. The Family Needs Survey was found to be somewhat useful to every family who participated, as each family was able to identify areas which they required services and areas in which they were functioning well. The

use of the Family Needs Survey prompted a lot of discussion surrounding the need for families to receive written information from service providers outlining potential service options when they first become open to the system. Families remembered feeling overwhelmed and confused when they first met their case manager, and a few families stated that they didn't even absorb information on service options during their first few visits with their FSW.

The Family Implications of Childhood Disability Scale (FICD) was described as both affirming family stressors and recognizing family and child strengths. This scale evoked the greatest degree of emotion in families as several families expressed identification with most of the areas addressed. Several of the single mothers identified that they felt that having a child with a disability had impacted upon finances, social supports, and contributed to a separation with their spouse. Other families identified that having children in general had implications for finances and stressors in relationships. It appeared that the positively framed implications gave many of the families a new perspective, in terms of what having a child with challenges has added to the family.

Several of the forms were helpful in identifying areas of family distress. The Parenting Stress Index (PSI) was most effective in recognizing families who were experiencing parenting as particularly difficult. However, when families indicated difficulties in family functioning and self-concept in addition to a large degree of parental stress, the student recognized a significant need for additional supports and resources. Thus, when families indicated that they felt trapped in their responsibilities as a parent (PSI), could not rely on family members to do their part (Brief FAM), experienced chronic stress in the home (FICD), and did not feel that they were a person of worth (Parent Self View), it was evident that the family was not functioning well. Thus, when difficulties were identified by the Brief FAM, the Family Impacts of Childhood Disability Scale, the Family Functioning Style Scale,

the Parent Self-View, and the Daily Feelings Scale, overall family distress was apparent. When families only identified parenting, family functioning, or self-concept needs, there did not appear to be the existence of overall family distress.

The social support scales were very effective in gaining an accurate representation of family perceptions of support, particularly when all were used in conjunction with each other. The Family Support Scale was typically administered first, giving the family an opportunity to think about who is in their network and how helpful they are. This scale was also effective in determining why potential sources of support were not available or being utilized. Once the family identified a person as particularly helpful, the student asked them to record that person's name onto the Social Network Inventory and to identify the ways in which that person is helpful. On a few occasions, particularly in large families who had a large number of supports involved with their family, the student would also assist the family in the development of an eco-map, to assist the family and student to develop a better visual image of who was involved with their family. The student also drew upon the Grandparent Support Index, as the degree of support gained from grandparents had implications for how supported the family felt in general.

In addition to the measures, it was important to ask families what their ideal support network was, as it is not accurate to assume that a small network is insufficient for some families. One single mother did not identify any family members or friends in her support network, however, was satisfied with support from one friend and a few professionals, and viewed further "support" as an intrusion. Thus, the most important information to gather regarding supports is the degree to which the family's actual support network is consistent with the family's ideal support network.

Although the initial plan was to use all twelve measures for each family, the student only used a portion of the measures with a few of the families. Some of the families were openly not interested in filling out twelve forms, thus, the student needed to decide which forms to omit, at the same time ensuring that the family had the opportunity to share information in all relevant areas. There were some common patterns identified regarding the types of families who tended to not respond well to particular measures.

Families who were composed of two parents and had children who were adolescents tended to find the family functioning scales useful. However, there were only two families involved in the practicum with these characteristics. Most of the families that participated in the practicum were single mothers with young children. These families tended to view these measures as irrelevant to their family, as they did not view communication, problem-solving, decision-making, and dealing with conflict as issues for them. The student suggested that these families fill the measures out in terms of extended family, however some parents still did not find the measures relevant, as they did not perceive their parents and relatives as involved in daily family matters. These families were more interested in focusing on needs of individual family members and the areas in which they would benefit from increased support.

The student recognized, however, the potential for these measures to facilitate discussion regarding parental stressors of single parenthood. When parents advised that they were responsible for all decision making and problem solving, discussion often ensued regarding their need for support from either informal or formal supports.

Some families who receive services from Children's Special Services do not perceive their child's needs as significant, and do not find scales relevant that focus on stresses of parenting and the impact of the disability on their family. A

few of the families found the Parenting Stress Index and the Family Implications of Childhood Disability Scales to be irrelevant and in some cases, negative. These families viewed their child who had a diagnosis as having contributed to the family to the same degree as their other children. As well, questions about the impact of disability upon family functioning and routines invoked reactions regarding the definition of normalcy that we may impose upon families. Several families could not remember a time when their routines were different, stating that they have developed family routines just like any other family with children. In most cases, the student was able to present the scales to these families as helpful in affirming the strengths of their family and their child. However, a few of the parents continued to express that the use of these measures assume a deficit approach.

Family Interaction with the IFSP

Each family who participated in the practicum identified with the concept of developing plans to meet both child and family needs. Families seem to appreciate the opportunity to share their concerns and priorities, as they see them, and to collaboratively work with their case mangers to problem solve. However, families respond in a variety of ways to the IFSP process depending upon their current life stage, the changing nature of child and family needs, and various structural characteristics, such as socioeconomic status and culture.

Family Life Stage

Families who responded most positively to developing an IFSP were families who had recently begun receiving services or who were currently undergoing a family transition, such as a child transition from day care to school, an upcoming transition into adult services, or a recent change in family structure (e.g., separation from spouse or marriage).

The development of the IFSP model was based largely on the need for more comprehensive planning to occur within the context of early intervention. Although the student did not have the opportunity to meet with many families who had entered the service system recently, the student recognized that the families who craved a greater degree of information and support typically were families who had pre-school aged children. These families were still learning about their child's needs and the types of services that were available. Furthermore, these families did not have access to other models of planning, such as Individualized Education Plans (IEP's) that are implemented in the school system. As these families had not yet had a lot of experience in interacting with various professionals regarding their child's needs, the family-centred approach which guides the IFSP process was potentially effective in empowering and enabling these families to take more of an active role in the development of future services for their family.

Families who were currently experiencing changes in their family were also very eager to discuss their concerns and to develop action plans in particular areas. One family chose to primarily discuss their concerns related to planning for their daughter to begin kindergarten. Another family discussed a lot of family issues and dynamics which had resulted from their recent blending of two families. Mothers who had recently become single parents often focused on financial and employment issues, social support, and self-esteem. Further, a parent whose child was almost age of majority was concerned about transitional planning into the adult system. These families appeared to find the process more helpful than families who were not currently dealing with family change.

The Changing Nature of Child and Family Needs

The student became aware that family situations and needs do tend to change rather rapidly. Many families indicated during the assessment session that the

responses that they provided, particularly to standardized measures, would have been very different a few months or even weeks ago. This finding can have strong implications for the way in which IFSP's are developed with families. The typical sequence of the IFSP process involves several meeting with the family, during which the case manager develops rapport, gathers information, and then assists in the development of a family plan. However, families experience needs which may change rapidly, sometimes before the team has met to develop action plans. The student found that framing needs in simplified and specific terms, and developing action plans as needs are identified, are effective ways of addressing the tendency for needs to change rapidly.

Expected outcomes are statements which indicate what is expected to occur as a result of the implementation of a plan. Parents may have several global needs, such as spending more time alone with their spouse, developing better parenting skills, or developing greater informal support networks. Parents may have global needs for their children such as the development of greater personal care skills, the ability to ride a bicycle independently, or the ability to interact safely with other children. It is the case manager's responsibility to assist the family to develop more specific simplified outcomes based on global outcome statements. For example, an outcome statement may be devised that allows the parents to participate in some social activities, "a respite worker will be recruited for Friday evenings to spend time with the children in the home so that the parents can attend their bowling league". Although the actual need for respite may not change, the family may require respite on a different evening in the future, which will result in the need to recruit a new worker. The more specific and simply stated the outcome statements are, the more adaptable the plan will be to family change. Furthermore, it is more effective to address a small number of immediate needs at a time, rather than devising several long-term plans at one IFSP session.

The student found that following the predetermined IFSP sequence was practical for some families, particularly when more long-term needs were identified and the team was able to meet for the IFSP session very shortly following the assessment sessions. Planning regular IFSP meetings with a variety of clinicians who are involved with the child's developmental needs appears particularly important. However, many of the families identified more immediate needs that should be addressed as soon as possible, and experienced changes between the time of assessment and the development of the plan. The student found that the IFSP process should be a working document, that allows for needs and action plans to be recorded as they are identified in order of priority for the family.

One mother discussed her need for a respite worker during the assessment session, and advised that she has been relying on a friend to provide volunteer respite. The FSW suggested immediately that this mother receive self-administered respite monies and pay her friend to provide respite. The need and action plan were identified during the same meeting, which was efficient, respectful, and practical. This particular family did not require the scheduling of an additional meeting to develop an IFSP document, as the planning occurred in conjunction with the assessment.

Other families will experience changes that require a reassessment of priorities during the IFSP session. One parent advised at the beginning of the IFSP session that she had just been told that her home care was cut back, despite her inability to care for four children while she was confined to a wheelchair. The need to reinstate a homemaker into her home quickly became the focus of the meeting, and previous priorities were considered secondary.

Socioeconomic Status and Culture

Structural characteristics of families, including socioeconomic status and cultural variables must be considered when working through the IFSP process, as these characteristics may influence the families' preferences regarding sharing information and the families' perceptions regarding priority needs.

Several families who participated in the practicum were low-income families who were either supported financially by social assistance or were employed in low-paying jobs. These families tended to not feel in control of many areas of their lives, and often, did not trust professionals. Thus, some of these families were initially reserved and did not share a significant amount of information about their family. When these families did share, they referred to past negative experiences with service providers (social assistance workers, school social workers) during which they did not feel respected. These families expressed that they had not had an opportunity to direct conversation, and had felt violated and intruded upon with a large number of personal questions. When meeting with low-income families, the student recognized that it was particularly important to emphasize that the purpose of the process was to determine what the parents' perceptions were of their needs and that they would not be pressured to discuss areas and pursue services that they did not feel were needed. The student recognized that these families were far more open to sharing information about their family when approached in this manner.

The families' socioeconomic status also appeared to influence the types of needs that were expressed by families. Families with lower socioeconomic status tended to focus more on global family and parental needs, rather than defining specific needs for their children. Needs such as assistance with parenting, day care subsidy, assistance in gaining employment, transportation assistance, neighborhood safety, and recreational opportunities were common priorities for

families with financial limitations. This finding was consistent with literature that asserts that when basic needs are not being met it is difficult to focus on needs of the child. It became clear, then, that case managers should not overwhelm families with discussion about child needs until some assistance is provided in accessing resources to meet primary family needs.

The student did not have the opportunity to meet with families from a variety of cultural backgrounds, however, based upon the student's interactions with a few diverse cultural groups, it became apparent that case managers must consider language and cultural practices when approaching families. The student met with a parent who's first language was not English, thus, the student ensured that questions and comments were framed using basic English, and that examples of various areas of discussion were provided. Furthermore, the student realized that it is particularly important to not make assumptions about family values and concerns. Culture may contribute to factors such as the family's utilization of social supports, their attitude towards services, and their perception of their child's needs. A mother with a Hispanic background was concerned that both her son and daughter who had disabilities would be encouraged to leave home, despite her wishes for her family to continue to live together. It was important that the student and case manager not assume that the family wanted to explore residential options as a component of future planning. A family-centred approach which encourages parental leadership demonstrates cultural awareness, in that the families' perception of their needs is respected.

Family Service Workers' Response to the IFSP Process

The student gathered feedback from FSW's following the completion of the practicum. A summary of responses to the feedback surveys is presented.

1) "How has your understanding of the IFSP been effected as a result of this experience?" Several of the FSW's asserted that the philosophies that they base their practice upon were reinforced by the principles and methods utilized throughout the practicum. These principles primarily related to the importance of facilitating family-directed goals in family-friendly language. Some FSW's reported having learned skills in the use of assessment tools and IFSP documents. A few FSW's asserted that they have gained confidence in the use of assessment tools, recognizing that families are in fact open to providing information in this manner.

2) "What component of the IFSP process do you find the most valuable for families?" Each FSW who participated recognized the potential for the IFSP model to facilitate relationship-building with families. FSW's noted observing that the extra time that was taken during the assessment phase enabled more sensitive listening to families' expression of their needs. FSW's also noticed that families were given the opportunity to provide information in a flexible manner - either through informal discussion, completing standardized measures, or both. Further, FSW's felt that the written plans were useful in bringing family goals and priorities to a more conscious level.

3) "What cautions do you feel need to be exercised in the collection and/or use of IFSP information?" Each FSW continued to demonstrate concern regarding the perceived increase in time that the IFSP process would require of them both during the initial assessment/planning stage and throughout the intervention process. FSW's are concerned that the IFSP model facilitates disclosure of a larger number of issues than they have time to address, and do not want to be put in a situation where they feel they are developing an expectation with families that FSW's can address all of the issues. FSW's continued to view the implementation of IFSP's as their own responsibility, despite the fact that the IFSP's that were developed tended to reflect an equal dispersement of action planning between

professionals and parents. One FSW emphasized that caution needs to be taken in responding to changing goals and priorities of families, recognizing that the IFSP must be an ongoing process. Another FSW felt that a greater analysis of the benefits of using standardized measures needs to be done.

4) "Other Comments...." Comments centred primarily around the role of professionals and families. Some FSW's emphasized the importance of allowing parents to drive the process, where other FSW's were concerned that the needs that parents were willing to engage in were not necessarily the real urgent ones from the FSW's perspective. One FSW felt that their roles as case managers and the implications for recording stated needs was a topic that needed further discussion. Further, FSW's recognize that they are only one component of a multi-disciplinary team and that more emphasis needs to be placed on other professionals' roles within the process.

The FSW's who participated varied in their philosophies in working with families to some degree, however, they tended to respond consistently with each other regarding their perceived value and concerns related to the IFSP. FSW's appear to agree that the IFSP process can be very beneficial in facilitating relationship-building with families, and encouraging parental direction of the process, however, concerns continue to exist regarding perceived increase in work load, the roles of case managers, and ability for FSW's to address various changing needs of families.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

Several educational goals were established upon the initiation of the practicum. The student wanted to understand families' experience with disability within the context of systems theory, to gain experience in the family-centred approach to intervention, to enhance knowledge of families' preferences related to developing IFSP's, to determine the benefits of various approaches to assessment, and to determine case managers' responses to the IFSP process. A discussion of practicum findings is organized based upon these goals. Further, implications and recommendations are presented for future research and practice.

Disability Within the Context of Systems Theory

The student's experience with families was consistent with the assertion that child disability impacts upon the family system. However, the way in which families react to and cope with disability will depend upon a variety of variables, which may include the particular needs of the child, characteristics of the family, personal characteristics of individual family members, and the social, economic, and environmental circumstances of families. Furthermore, all families have a variety of strengths from which to draw upon, which need to be emphasized when assisting families in determining their needs and concerns.

As disability occurs within the family system, interventions must recognize both positive and negative impacts upon families. A thorough assessment of family structure and functioning is essential in promoting healthy functioning for all family

members (Patterson & Garwick, 1994). As each family has a unique structure and interactional patterns, professionals who work with families must not make assumptions about family concerns or what families will need to function well. Furthermore, families understand the relevance of providing information about their family strengths and needs which may or may not be related to their child's disability. Thus, an approach to intervention which emphasizes families' knowledge of their situations, families' perceptions of needed resources, and family and professional partnership in implementing services, is a logical, respectful, and efficient approach to empowering and enabling families.

A Family-Centred Approach to Disability

Rosenbaum et al. (1998) assert that at the heart of the family-centred approach is the recognition that the family is a constant in the child's life. Thus, it is vital that services address the needs of all family members, involve a partnership between professionals and families, and recognize families as experts of their own children and family situations.

Conducting an in-depth assessment with the family facilitates the generation of information about the needs of all family members. Asking families what they want for each family member and discussing areas of family structure and functioning assists in gaining information about individual and collective family needs. Although families tend to identify goals that are related to their child with a disability, many of the needs that are expressed are parental or sibling issues related to more effective coping and functioning. Thus, it is vital that service providers expand assessment beyond the child to family members who are impacted by disability. The use of family assessment measures such as the FAM, the Family Functioning Scale, and the Family Implications of Childhood Disability

Scale, in addition to informal techniques of assessment, can facilitate discussion of family concerns.

There has been some disagreement in the literature regarding the implications for professional and parental roles within the family-centred model. Although a partnership model has been suggested, a consensus has not been reached regarding the ideal degree of parental involvement in the decision-making process. Recommendations have ranged from parents fully directing their services, to being equal partners in decision-making, to being consulted regarding service decisions. It is apparent that families do, in fact, differ in their desires and abilities to participate in service coordination. However, it is also apparent that families are capable of determining their own needs and in making decisions regarding suitable services when given the opportunity. Families are not always accustomed to being asked to actively participate in their relationships with health care, education, and social service professionals. Furthermore, parents are more apt to participate when they are approached with an atmosphere of respect for their unique knowledge, and are informed about the IFSP process and the service system. Bailey et al. (1986) suggest a "goodness of fit" approach to assessment and implementation of services, which requires that case managers pay attention to family characteristics which indicate their preferred level of involvement.

Case managers must be cognizant of common barriers to parental involvement and implement techniques which will facilitate empowerment, thus, resulting in a greater degree of parental-direction of services. It is apparent that many families live in oppressive circumstances that prevent them from being willing and able to participate in service development. Therefore, it is the role of case managers to engage in helping behaviors that enable families to maximize the use of existing

competencies and to develop new competencies that will assist them to mobilize needed resources (Dunst, Trivette, & Deal, 1988).

There are a variety of ways that families can be encouraged to use existing competencies. Case managers can assist families to become involved in establishing services for their family by informing parents of their rights as parents, informing families of the IFSP process and the family's right to lead the decision-making process, encourage families to lead the assessment process by sharing family concerns and priorities, emphasize child and family strengths, and involve families in carrying out action plans to get needs met.

However, it is also the responsibility of the service system to assist families to develop new competencies which will adequately enable parents to participate in service development. Families must be assisted to develop knowledge of the service system, informed about available education, community and medical programs, and assisted to become advocates for their child and family. Families frequently report that they would have appreciated a more comprehensive description of the services available to them upon the initiation of their involvement with Family Services. A written resource guide outlining service options and the steps required to access those services would alleviate the overwhelming nature of seeking support. Furthermore, initially providing parents with more information would teach families to get their own needs met, resulting in a more rapid phasing out of intensive professional involvement.

It is apparent that some families will require more intensive support in learning how to actively access the service system. However, the majority of families will respond well to being encouraged to utilize already existing competencies, which may include positive family functioning, and use of internal and external coping resources. Families should have the opportunity to receive a comprehensive orientation of the service system upon referral. The orientation could either be

formally provided in a group setting, or be provided by their appointed case manager. Involving experienced parents in conducting orientations for new parents can be an empowering experience for both sets of parents.

Regardless of the degree of capabilities initially exhibited by families, parents know their children better than service providers as each child is unique and develops within the family system. Professionals need to approach families with respect and draw upon existing strengths.

Family Preferences Regarding the Development of IFSP's

Families are typically interested and sometimes relieved in having the opportunity to share their needs and concerns and to participate in developing a comprehensive plan for their child and family. Families who have a pre-school aged child, have just been referred to the service system, and are experiencing life transitions appear to find this process particularly helpful. However, as each family and child is unique, families differ in their preferences regarding the techniques utilized to gather information, the process of developing family plans, and the sequencing of the IFSP process. Thus, the development of the IFSP must be very flexible and respond to individual family cues. It is clear, however, that families prefer to more actively participate when informed about the process and approached as an equal partner.

It appears that both the use of formal and informal methods of assessment are found useful by families. Although families tend to prefer an informal setting in which needs and concerns are discussed, most families find value in filling out standardized measures which reflect areas that are relevant to them. Parents are more apt to actively participate in the assessment process when they are familiar with the IFSP process, are provided with copies of IFSP measures, summary forms, and documents, are given the opportunity to fill out their own measures,

and perceive themselves as in control of areas of discussion. A natural way of facilitating parental direction of IFSP sessions is to provide families with a summary of the needs that they have identified and structure the meeting based upon their chosen priorities. A small number of needs are typically addressed at IFSP sessions as families find it too overwhelming to discuss all needs that have been identified.

Families are not always as interested in filling out the IFSP document as they are in having a written document to refer to that reminds them of the current plan and each team members' responsibilities in implementing that plan. Families also tend not to be extremely concerned with the wording of outcome statements and action plans, as long as family-friendly language is used. However, concretely written goals set families up for success as they are more achievable and measurable. Parents can also more naturally be enlisted to participate in action plans when they are written in specific formats.

When IFSP's are developed in ways which affirm the nature of child and families' changing needs, the process is viewed as more beneficial to families. As both child and family needs are subject to rapid change, case managers must be flexible and responsive throughout the process, and refrain from imposing their own agenda upon the family. This flexibility and responsivity can be achieved by developing plans with families throughout the assessment period, developing short-term rather than long-term goals, and following up with families in 3-6 month increments. Families find that meeting with case managers to discuss family needs and global child needs can be an effective introduction to the planning of a child-focused meeting with involved clinicians.

Although families differ in their preferences in developing child and family plans, all families respond more positively to the process when they are informed, encouraged to actively participate, and when goals are developed which are

concise, realistic, and responsive to their changing needs. Case managers need to follow parental cues and to assist in the development of plans that instill hope in families. Furthermore, it is vital that assumptions are not made about what families need, as various factors, including culture and socioeconomic status, may influence families' priorities and response to the IFSP process.

Applicability of Various Assessment Techniques

Both formal and informal techniques can be effective in gathering information on child and family needs. However, it is important that assessment is viewed as an ongoing process which requires that families and professionals work together over time to maintain a plan which reflects the changing circumstances of family life (Johnson et al., 1994). Thus, the techniques that are used to assess child and family strengths and needs must be sensitive to change.

The utilization of a comprehensive set of assessment measures which gather information about child and family strengths and needs, and actual and required resources, can be effective in prompting the retrieval of family information, facilitate more in-depth discussion in a non-intrusive manner, and emphasize the strengths in children and families. Furthermore, the utilization of standardized measures can facilitate a parent-directed process. Encouraging parents to complete standardized measures tends to result in more active participation in the IFSP process (Minke & Scott, 1993). Furthermore, particular measures are perceived as helpful when they address issues that are relevant to families. For example, the Family Needs Survey can act as a checklist of potential services to families who are new to the system. The Parenting Stress Index can normalize care giving stress that parents may be experiencing.

Informal methods of gathering information are preferable to some families, particularly when families approach the system with clarity about their needs and

strengths. Families who demonstrate a small number of needs from the service system may prefer open-ended questions, such as "What would you like for your child in the next 6 months?". Informal discussion, rather than a checklist of questions, can also facilitate a family-directed process. FSW's can gather a large degree of information on the child, family, and service needs by allowing parents to share information and asking questions related to that information. For example, when a parent asserts that she is tired, the case manager can ask several questions about the child's sleep patterns, their access to formal and informal respite, and their routines. Parents feel more comfortable when questions asked are natural and relevant.

Case managers must be aware that the initial assessment will provide professionals with a basis for the development of services, and that a regular review of current family needs and concerns may be required. Thus, one can not assume that assessment is complete once a comprehensive child and family assessment has been completed upon intake. The IFSP document can serve as an ongoing reflection of family needs and priorities. During follow-up meeting with families, needs can be reassessed by asking families if they feel that particular needs have been met, what is working and not working about the plan, and what other needs have become priorities for families.

It appears that completing a comprehensive assessment of both needs and strengths can be the most important part of the IFSP process, as some families feel confident in pursuing supports quite independently when they are clear about their own priorities. Families also really appreciate a summary of identified and observed strengths and needs, finding the emphasis on strengths empowering. Spending some additional time with families in carrying out an in-depth assessment will provide a structure for IFSP sessions, may be therapeutic in providing families with opportunities to discuss aspects of family life, and may

contribute to more effective and efficient planning so that case managers are able to decrease their involvement with families over time. An in-depth parent-directed assessment is vital to beginning the process of helping families to get their own needs met, rather than attempting to meet family needs as perceived by professionals.

The Response of Family Service Workers to the IFSP Process

The FSW's who participated in the practicum generally responded very positively to the principles and methods demonstrated by the student. Some FSW's characterized the practicum as a learning experience, however, others stated that the experience confirmed their already established beliefs and practices with families. The actual methods employed, specifically the use of tools, summary forms, and IFSP documents were typically new to most of the FSW's, thus, the practicum served the purpose of determining the potential benefits of an interactive approach to consultation. The literature consistently recommends that case managers who implement the IFSP process have the opportunity to attend workshops on principles of the family-centred model and effective IFSP techniques.

It is apparent that the opportunity for FSW's to directly observe the implementation of the IFSP process can be a particularly effective means of achieving skills and understanding of various components of developing IFSP's. Particular benefits include the opportunity to hear the philosophy and purpose behind the IFSP, to observe families' response to various assessment tools, to discover techniques to facilitate parental participation, to develop methods of summarizing strengths and needs which can guide planning, and to observe and participate in writing IFSP documents. Participation in writing IFSP's can facilitate skills in writing concise and specific outcome statements, writing in family-friendly

language, and in developing problem-solving skills in developing action plans. Direct observation and involvement in the IFSP process would be an effective way of providing training to case managers who are new to the position or unfamiliar with the IFSP. However, there are some limitations to this form of staff consultation.

Every family is unique and will respond differently to the development of an IFSP. Thus, the observation of one IFSP process will not provide case managers with a full representation of families' preferences and reactions. This form of training will not necessarily reflect the need for flexibility in gathering information and developing plans. Furthermore, the observation of the IFSP process should be the second stage in developing skills in implementing family-centred practice. FSW's who do not understand or embrace the basic principles of family-centred practice will not necessarily fully internalize the methods observed. Johnson et al. (1994) assert that IFSP teams must clarify the principles which will guide the process before the problem-solving process can be useful. Thus, the provision of training regarding the basic premises behind family-centred practice is a practical first step. Finally, some families will be more open and find the assessment process less threatening when meeting with one staff instead of two. Discussing personal family issues with two staff may feel less intimate and more intrusive.

FSW's may also respond more openly to receiving an orientation on family-centred practice and the development of IFSP's from staff who are internal to their program. In other words, individuals who currently work, or who have worked, within their system may be perceived as having a greater understanding of barriers to particular methods of practice, which may include case load and scheduling issues, mandates and program procedures, and interdisciplinary team and systemic issues. However, it is important that programs are open to learning from the experience and knowledge of external systems.

The provision of workshops for both parents and staff is an integral component to ensuring that IFSP's are developed which respond to family needs and concerns, facilitate a partnership between professionals and parents, and are sensitive to the individuality of families. Involving experienced staff and parents in the provision of training will assist in facilitating empowerment and commitment to the process.

Conclusion

The purpose of the family-centred model of practice is to strengthen family functioning, moving beyond a narrow focus on the developmental needs of the child. The IFSP has been developed as a framework to facilitate this expanded focus, emphasizing the needs and strengths of the entire family, relying upon the expertise of parents, and encouraging active participation of parents in determining needs and developing services. Although barriers to effective implementation of the IFSP have been identified in the literature, it is apparent that a comprehensive knowledge and internalization of principles of family-centred practice can assist service providers to promote the development of practical and effective plans with families. Furthermore, the IFSP process can facilitate relationship-building between professionals and parents and empower families at an early stage to become advocates and leaders in meeting the needs of their child and family. Child disability impacts upon families in a variety of ways. However, programs which emphasize the strengths and abilities of children and families by encouraging parental involvement in the planning process will result in more long term benefits for both families and professionals.

APPENDICES

THE UNIVERSITY OF MANITOBA

FACULTY OF SOCIAL WORK

Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-7050
Fax: (204) 474-7594
E-Mail: Social_Work@UManitoba.CA

CONSENT FORM FOR PARENTS PARTICIPATING IN DEVELOPMENT OF IFSP

I, _____, consent to participate in the development of an Individual Family Service Plan (IFSP) with Tricia Klassen (475-9482), a Masters student from the Faculty of Social Work, at the University of Manitoba, and my Children's Special Services (CSS) worker. Tricia is completing her practicum on IFSP's under the direction of Dr. Barry Trute (474-9798), Dr. Diane Hiebert-Murphy (474-8283), and Kathy Levine (474-7461), her practicum committee. I am aware that the practicum has been approved by the Joint-Faculty Research Ethics Board (JFREB) and that I may contact Professor Wayne Taylor (474-7122), Interim Chair, should I have any concerns about the procedures used in this practicum.

I am aware that the practicum is intended to advance understanding of the use of the IFSP and that information collected will specifically contribute to knowledge on family preferences regarding the development of IFSP's. I recognize that the development of an IFSP will take 1-3 sessions, approximately 3 hours. I will allow the sessions to be audiotaped.

I understand that my participation in the study is voluntary and that my decision to participate or not will not affect the services I receive from CSS. I understand that I do not have to answer any questions that I do not want to and that I am free to withdraw from the practicum at any time. I am aware that all information generated as part of this practicum (audiotapes, transcriptions, questionnaires, notes) will be placed in a research file and kept separate from my CSS file. All practicum information will be destroyed at the conclusion of the project. The final IFSP document will only be placed in my child's CSS file with my consent.

The final IFSP document may be added to my child's CSS file. ____yes ____no

I also understand that Tricia will not have direct access to my child's CSS file, however information in my file may be verbally shared during the IFSP sessions. I understand that any information I provide will be kept confidential with the exception that if any information is shared about children being at risk of abuse this information must by law be reported to the mandated child welfare agency.

I understand that general findings of the practicum will be summarized in a practicum report and may be written about in professional journals.

Date: _____

Signature: _____

Summary of Strengths and Needs for the Johnson's Individualized Family Service Plan

Family Strengths that were identified:

- the family makes decisions together
- parents take time for themselves when they need a break
- the family laughs together
- parents are flexible and match their pace to that of the children
- the family eats dinner together
- the family knows who to call when they need support
- parents worry about their child, demonstrating concern for their child and a desire to do things right
- parents are creative in finding ways to keep their child stimulated
- the family is active and participates in the community

Child Strengths that were identified:

- child has a determined personality
- child is a social boy with a great sense of humour
- child keeps the family happy and enthusiastic
- child is imaginative, charismatic, and full of energy
- child simplifies things
- child has many interests, such as music, acting, computer

Family Needs that were identified:

- ability to choose and coordinate respite services (self-admin. respite)
- to find a job which suits children's school schedule
- meeting other parents who have children with similar needs
- to be more involved in their child's school program
- to learn more about helping their child control his behavior
- would like to go out more as a family (financial/transportation limitations)

Child Needs that were identified:

- to have more friends to spend time with
- to learn to ride a bike without training wheels
- to be more independent in school (including toilet training)

Individualized Family Service Plan

Family Name: _____ **Child's Name:** _____

Worker Name: _____ **IFSP page #** _____

Date	Need (outcome statements)	Supports/Resources	Course of Action	Evaluation
	What is to occur and what is expected to be accomplished.	Family Friends Community Resources Education, medical	Specific responsibilities of each person and goal date	
March 1/ 2001	Jane will attend preschool two mornings per week so that she has a chance to	Family Servile Worker DayCare office	Family Servile Worker will provide a list of day-cares in area (Mar. 8/01)	
	play with children who can stimulate her social development.		Family will schedule tours at nearby Centres (march 22/01)	
			Family will place Jane's name on waiting lists (April 6/01)	

Evaluation

1. Situation Changed, no longer a need 2. Situation unchanged, still a need. 3. Implementation begun, still a need
4. Outcome partially attained 5. Outcome accomplished, family not satisfied 6. Outcome accomplished, mostly to family satisfaction.
7. Outcome accomplished to family satisfaction.

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