How to implement the family-centered model in early intervention

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Título: Cómo implementar el modelo centrado en la familia en la intervención temprana.
Resumen: A partir de los resultados de una investigación encaminada a la mejora de la calidad de vida de las familias con un hijo o hija con discapacidad intelectual, el objetivo del presente trabajo es ofrecer una propuesta metodológica para la implementación del modelo centrado en la familia en los centros de atención temprana de nuestro país. Los análisis cuantitativos y cualitativos de los datos recogidos nos permiten sistematizar los pasos o fases que sería necesario seguir con el fin de proporcionar herramientas útiles a los profesionales y a las familias de los centros de atención temprana para promover el desarrollo de los niños y el empoderamiento de las familias. El artículo supone un paso adelante respecto a las propuestas realizadas por otros investigadores de otros países con tradiciones y cultura diferentes en el ámbito de la atención temprana y trata de recoger las características y la idiosincrasia de nuestro país en cuanto a la historia y la trayectoria de la atención temprana en las últimas décadas.
Palabras clave: atención temprana; trabajo centrado en la familia; niños con discapacidad; niños con trastornos del desarrollo.

Abstract: From the results of a research aimed at improving the quality of life of families with a child with intellectual disability, the purpose of this paper is to provide a methodology for the implementation of the family-centered model in early childhood intervention centers in our country. Quantitative and qualitative analyses of the collected data allow us to systematize the steps or stages that would be necessary to provide professionals and families in early intervention centers with useful tools to empower the families and to enhance the children's development. This article represents another step further from the proposals made by other researchers in other countries with different traditions and culture in the field of early intervention, and intends to reflect the characteristics of our country in terms of the history and the path of early intervention in recent decades.
Key words: early intervention; family-centered model; children with disabilities; children with developmental disabilities.

Introduction

This paper shows the results of a research project targeting the progress and improvement of professional practices in services for families with a child with an intellectual disability in the field of early intervention in Spain. It is also intended as a contribution to the transformation process of early intervention services which *Plena Inclusión*, an organization comprising all parents' associations in the field of intellectual disability in our country, has just set up.

The joint work of families, professionals in Early Childhood Intervention (ECI) centers, and researchers throughout the entire research project has implied the exploration of collaboration ways which have clearly contributed not only to continuously improving the project and achieve results, but also to enriching all participants. Particularly, the quantitative and qualitative analyses of collected data allow us to systematize the steps or phases to be followed and, in short, to provide professionals in ECI centers in our country with a working and organization protocol that includes different procedures and instruments to implement the family-centered model (FCM) in their centers. The difficulties and challenges that the implementation of this model has involved for the families, professionals, and researchers taking part in this research project are considered in the framework

of proposals that in the last few years such renowned authors in the field of FCM as Bruder (2000), Dunst and Trivette (1987, 1996, 2009), Dunst, Trivette, and Hamby (2008), Espe-Sherwindt (2008), Leal (1999), and McWilliam (2010a, 2010b, 2011) have presented.

The FCM, which is described below, implies a change of perspective concerning professional practices in early intervention, and has a long tradition in such countries as the USA, Canada, United Kingdom, Australia, etc., as well as the support from many research projects that show the huge benefit that the FCM means for the child's development, and for the functioning and well-being of families. Particularly, Dunst, Trivette, and Hamby (2007) showed through a meta-analysis of 47 studies that the family-centered model has a positive impact on the behavior and functioning of the family in general and the parents and the child with a disability in particular. Other studies have given evidence of the improvement of outcomes in the child's development when working from interventions more centered on natural environments, such as the family. Dunst, Trivette, Humphries, Raab, and Roper (2001), for instance, showed that the children's progress is higher when interventions are carried out from informal supports (such as the family) in contrast with formal supports (services); Kasari, Gulsrud, Wong, Kwon, and Locke (2010), in their turn, observed that it is the quality of the parents' participation, rather than the number of sessions with professionals, that is linked to the set of progresses achieved by the child. With regard to benefits for the family, results from different studies show that family-centered practices contribute with greater psychological well-

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being and satisfaction of families with services received (Dunst, Hamby, & Brookfield, 2007; Rosenbaum, King, Law, King, & Evans, 1998; Stallard & Hutchinson, 1995), as well as the fact that it becomes the guidance that families ask for more as it meets their expectations (Carpenter, 2007; Espe-Sherwindt, 2008).

In our country, although the White Paper on Early Intervention (GAT, 2000) clearly states that the intervention has to focus on the child, family, and environment, reality is that the working models are still centered mainly on the child with a rehabilitating approach. For this reason, in this past year *Plena Inclusión* has started a process to transform the early intervention services of its affiliated members, involving (1) the adoption of an ecological and systemic approach to human development and intervention; (2) the recognition of the importance of natural contexts and daily routines for development; (3) the promotion of parent empowerment; and (4) the promotion of a collaboration model between families and professionals that recognizes the prominence of families and replaces the current model based on the role of professionals as "experts".

Every change implies insecurities, imbalances, logical resistances that should be tackled from respect, training, and provision of materials and guidelines for the practice. In this respect, this article is a step further from proposals presented by other researchers from other countries with different traditions and culture, and intends to collect the characteristics of our country concerning the history and itinerary of early intervention, which has already been reviewed in previous studies (Giné, Gràcia, Vilaseca, & García-Dié, 2006).

Thus, we first explain what is currently understood as family-centered model (rationale, conceptualization, and basic elements of the model) according to research and evidence available. Then, we describe the different steps or phases that, according to the results of our research, make up the proposal of intervention to implement the FCM. Finally, we include some considerations on the possible positive consequences for the family and child.

The Family-Centered Model

The services for people with a disability and their families have experienced different changes in the last decade, both concerning the conceptual models and the professional practices and social recognition.

Historically, the services for people with a disability at an early age have tended to focus mainly on the child; consequently, the priority was to deal with the consequences of the deficit by adopting a rehabilitating approach. As a result, work with families was usually disregarded and always perceived as a complement to the work carried out with the child. The birth of a child with a disability was perceived as a problem that led the family to a crisis, which required psychotherapy, which started with a crisis and ended up with acceptance (Turnbull, 2003; Turnbull, Turbiville, & Turnbull, 2000). The relationship of professionals with families was based on the expert model, establishing a clearly asymmetrical relationship with the professional having the power and taking control of decision-making processes on the basis of their professional competence; they knew what was wrong with the child and therefore were able to tell the parents what they had to do with their child (Turnbull et al., 2000; Vilaseca, Gracia, Giné, & García-Dié, 2004).

Progressively and as a result of contributions from the *family systems* theory in the 60s and the *ecological systems* theory of development in the 70s (Bonfrenbrenner, 1987), in the late 90s a new way of understanding and caring for people with a disability and their families emerged in our country (Leal, 1999; Turnbull, 2003). The family systems theory contributed to see the family as a complex social system, defined by its own unique characteristics and needs. Families were thought to be a network of reciprocal relationships where the experience of every family member affected the other individuals that are part of the family. In its turn, the ecological theory understood human development to be the result of the interactions that people have in the different life environments that they participate in directly or indirectly such as home, school, neighborhood, or community. Bronfenbrenner (1987) described a set of influence systems (microsystem, mesosystem, exosystem, and macrosystem), with every system being included in the previous one and changing throughout the lifespan.

As a result, these conceptual changes at an international level were little by little influencing professional practices, shifting from a more clinical, rehabilitating model to a more educational model, therefore more concerned with the improvement of family educational practices. Indeed, by accepting that families with a member with a disability have their interactions affected as a result of the evolutionary characteristics of this person (Giné, 1995; Guralnick, 1998; Lacasta, 2000; Lecavalier, Leone, & Wiltz, 2006; Turnbull et al., 2004; Van Riper, 1999) and that the family is recognized as the developmental context par excellence, we assume that families have to be at the center of attention (Freedman & Capabianco, 2000; Rosembaum et al., 1998). It is in this framework that the family-centered model has full meaning and justification (Allen & Petr, 1996).

In short, the family-centered model is mainly a philosophy, beliefs, and values from which professionals intend to support the development and capacities of families in order to promote the progress of the person with a disability (Dunst, Boyd, Trivette, & Hamby, 2002). Throughout the last decades, evidence has been collected of its efficacy in the care of children with a disability and their families in early intervention centers (Freedman & Capabianco, 2000; Espe-Sherwindt, 2008; Dunst, Trivette, & Hamby, 2008; Law, Rosenbaum et al., 2003; Law, Teplicky et al., 2005). Indeed, research has shown that, when parents commit to their children's care, better outcomes are achieved, not only for the children with disability but for the entire family (Dunst & Trivette, 1996; Dunst, Hamby, & Brookfield, 2007).

This model puts the emphasis on understanding child development in a more holistic and more contextual way; the child's progress is recognized as not responding to a sum of partial interventions but to a global vision which finds the best expression in preferential care at home and in the community. Natural environments, i.e. family, school, and community, are now recognized as the contexts to promote development par excellence. Therefore, the child's progress is no longer associated with treating the deficit but to the favorable opportunities and experiences that promote their active participation at home and at school from daily routines. In this respect, the real critical aspect is now the empowerment of parents, without disregarding the specific care that some children may need, logically.

Allen and Petr (1996) stated that there are two elements of the family-centered perspective that are shared by most authors that have significantly contributed to developing this approach: that families can choose, and that the intervention is based on the family's strengths. In this respect, Leal (1999) observed that the more centered on the family an approach is, the more opportunities the family members will have to construct on family strengths, without trying to correct weaknesses, so that families can increase the personal control of the situations that affect them and their decision-making.

Turnbull (2003) and Brown, Galambos, Poston, and Turnbull (2007) agreed that the essential characteristics of the family-centered model are as follows:

a) The family is conceived as a *support unit;* that is why intervention is no longer centered only on the child with a disability and his/her mother.

b) Respect for the *family's choice.* The family now has a voice and can express their needs and preferences concerning issues that have to do with the family and their child with a disability. As a result, the family has an active role in the selection of goals to work on and in the way of tackling and assessing them. The role of professionals in this process has to be that of a guide and advisor (Dunst, Johanson, Trivette, & Hamby, 1991).

c) Emphasis on the *family's and contextual strengths.* Pathological approaches (limitations) are disregarded, and actions aimed at promoting competences and possibilities of the family environment are more relevant.

Later, Espe-Sherwindt (2008) added to these three characteristics the need to develop collaborative relationships between families and professionals, collecting the experience and research of the last few years. Moreover, Turbiville, Turnbull, Garland, and Lee (1996) advocated the collaboration between families and professionals as the path to be followed from the family-centered model. Thus, the collaboration between families and professionals is thought to be one of the principles of family-centered intervention (Turnbull et al., 2000) and a key element to empower families (Dempsey & Dunst, 2004; Dunst & Dempsley, 2007; Dunst & Trivette, 1996; Trivette, Dunst, Boyd, & Hamby, 1995).

Blue-Banning, Summers, Frankland, Nelson, and Beegle (2004) understood the collaboration between families and professionals on the basis of mutual support interactions that are aimed at identifying the needs of the children and their families, and are characterized by their sense of competence, commitment, equality, communication, respect, and trust. Summers et al. (2007) observed that the professionals will be able to establish a collaborative relationship with families when a set of factors that act at different levels are met; some in the interpersonal domain and others being more structural. Among these interpersonal factors, Blue-Banning et al. (2004) included a set of personal characteristics (attitudes, skills, values, and beliefs) that contribute to creating an ideal interaction atmosphere so that a real collaborative relationship can be constructed (see Figure 1).
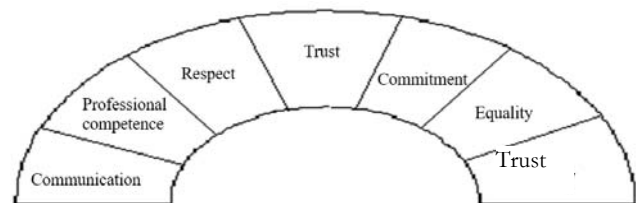

Figure 1. Attitudinal principles to establish a collaborative relationship (adapted from Turnbull, Turnbull, Erwin, & Soodak, 2006).

In their turn, structural factors are made up by aspects related to the system of services and, therefore, have to do with administrative regulation and the organization and planning of resources by the centers themselves (Summers et al., 2007).

In short, the aim of FCM is to empower and prepare families to function effectively in their social contexts (Leal, 1999). That is, to promote the skills of families so that they can function effectively in their daily life and as a result promote their quality of life; as observed by Turnbull (2003), we have to understand empowerment as a process and the family quality of life as the outcome.

Intervention Proposal

1st step: Assessing family and child context

The main difference between traditional practice in early intervention so far and the adoption of the family-centered model lies in the importance of assessing the child's context, understood not only as their closer environment but also as their daily routines. Every intervention has to be preceded by the exploration of the child's level of competences; to do so, the developmental scales already known in early intervention such as Merrill-Palmer Scales of Development (Roid & Sampers, 2004), Bayley Scales of Infant Development (Bayley, 1977), etc., are used. But this model goes beyond this, by posing the need to focus on what the child does every day, who with, and then be able to help to develop their skills to the full in and on the basis of daily activities.

Daily activities are significant for the child because they happen every day precisely, in a known environment, with their materials, and with significant people; and all these aspects are the critical components to promote learning (Dunst, Bruder et al., 2001; McWilliam, 2010b). Consequently, it is necessary to know these activities in order to design an intervention in accordance with their nature. With this purpose, we use the semi-structured interview (the Routines-Based Interview), where the family's daily routines are collected, and the parents' level of satisfaction with every one of them is assessed. From this, family concerns emerge, which once transformed into needs will be the functional goals of the individualized plan. The Routines-Based Interview (McWilliam, Casey, & Sims, 2009), henceforth RBI, has two moments. The first moment is that of preparation, where the family is told the objective of the interview, its duration, they are asked to think about the routines that they engage in at home with their child, and are proposed to think about their main concerns. Preparing this session with the families is important because there are usually questions, reflections that they might have shared with other significant members of the child's environment, which are really important for the RBI's success.

The second moment is that of the RBI in the strict sense. The interview is about two hours long, and participants talk about the routines of the family in general and the child's routines in particular. For every routine, family members are asked to explain what every family member does in that routine; and in particular, they are asked, in relation to the child, to focus mainly on four aspects: the child's participation in the routine, their autonomy, their communication, and their social skills.

An aspect to be considered is that the RBI is an interview where families explain, apart from their family functioning, personal aspects and this is why it is very important to create a warm, unprejudiced emotional atmosphere. In any case, we have to consider that the RBI is an assessment instrument, so there is no intention to carry out some specific work while doing it yet. It is advisable not to give any guideline now, as this is a moment of getting to know and listening to, with the intention of getting a good understanding of the family and their functioning in order to collaborate with them later. Nevertheless, we should state that experience shows us that on many occasions the RBI has had a therapeutic role, helping parents to stop and think and put their own thoughts and emotions in order; on many occasions, it has also revealed not only needs and goals but also solutions that have emerged in the personal and trusting dialogue.

In the family-centered model, professionals are expected to put their role of experts aside to become a collaborator, facilitator and put themselves by the family in order to advance together in the individualized intervention program. In this sense, the RBI is the first moment of approach. It is the initial moment when the family opens up and starts to feel the protagonist of their child's intervention. For this reason, it is important to watch over this initial moment, because it is the entrance door to the collaborative relationship.

There is also another assessment instrument for children in the family context. The Measure of Engagement, Independence, and Social Relationships (MEISR) tool (McWilliam & Hornstein, 2007) is a scale of participation, autonomy and social relationships that helps both families and team members to assess the child's competences on a day-to-day basis. This scale divides competences in daily routines by age ranges, which allows the family to see the strengths and needs of their children when doing these routines.

Another basic instrument to assess context aspects is the ecomap (McWilliam, 2010a). The main objective of the ecomap is to help families and professionals to identify their formal and informal supports, as well as the relationship that they establish with each of them. The drawing of the ecomap starts by asking the family who lives with the child, and then they are put in a central box on the sheet, including both the parents and siblings and those other significant people that may live at home, thus making the standard genogram more flexible. Then they are asked about other family members such as grandparents, uncles and aunts, other relatives, close friends, and neighbors that are important for the nuclear family, and they are put in separate boxes at the top of the sheet. After, they are asked about formal supports of the family (the ECI Center, medical services, educational services, possible treatments that the child is getting, income sources, and other services that the family is getting), and they are put in separate boxes at the bottom of the sheet. In the middle of the sheet, on both sides, we put the parents' workmates, recreational activities of the family, and social groups that they belong to, including their religious community if appropriate. Once all the members surrounding the family are written down, they are asked whether some significant person/entity is missing.

As mentioned, the role of the ecomap is to make the supports that families have apparent to the parents and professionals and to find out whether there is a balance between formal and informal supports as informal supports are particularly important to promote the well-being of all the family members (Giné et al., 2013; Park et al., 2003). The ecomap allows us not only to explore the amount of supports but also the quality and intensity of each one of them; to this purpose, there are such questions as 'what is the relationship with every annotated member like?'; 'how do you get along with the person in particular?'; 'how often do you see or talk to them?'; 'if something happens to your child, who do you call or go to?'; etc. In this sense, we will know what family members there is a more intense relationship with, which will be shown in the drawing with a thicker line; normal lines represent moderate support agents, and thin lines represent those agents that are present but do not provide much support. We will also draw, if appropriate, sources of stress by using dashed lines; it is those close people that, more than support, cause anxiety in some family member. The length

of lines also depends on the intensity of the support, the more support, the longer the line. There can be two different lines towards the same family member; for instance, a grandmother that gives a lot of support (represented with a long, thick line) but that causes stress in the mother (represented with a dashed line). This information helps us to understand the psychological affinity with the network of supports, as well as the availability of the family members and the congruence among needs and support received.

In short, the ecomap helps both the family and the professionals to ecologically understand the family reality, giving importance to the entire context, not just the child; furthermore, it has the advantage of being a simple task that can be done in 15 minutes.

2nd step: Writing down functional goals

After carrying out an assessment that allows us to identify the needs and priorities of the families and their children, the professionals together with the families will start to write down the goals to be achieved with the intervention (McWilliam, 2010a).

The functional goals define the skills or behaviors needed to participate in activities or daily routines, reaching the top level of development possible. In their writing, the family defines what they would like to happen, and the professional, on the basis of their knowledge, points at the strategy to use in order to achieve it (Cook & Younggren, 2013).

Following the principles of family-centered practices, the goals of the Individualized Family Service Plan (IFSP) should meet the following criteria (Lucas, Gillaspy, Peters, & Hurth, 2014):

1. They are functional and needed for the child and family to be able to participate in the activities that are important for them. The goals are always established on the basis of what the family considers to be necessary and functional for them, not on the basis of what the professional thinks or believes to be useful or significant in their lives (Pletcher & Younggren, 2013).
2. They reflect real situations of daily life and routines of the families, such as having meals, baths, going to the park, etc. Often, the goals set up by developmental areas are neither contextualized nor represent situations of daily life.
3. They describe the participation of the child and/or family in routines, which means that in the writing it is the child or family that are the "actors", not the professionals.
4. Their writing has to be free of jargon, using daily routines and activities.
5. They always emphasize positive actions, identifying what the child or family can do, rather than what they cannot do.
6. Active voice is preferred to passive voice; expressions that imply involvement and active participation of the child/family.

The strategies have to respond to activities to be carried out by the family within their routines rather than to therapeutic activities provided by a professional with specific materials, more in the line of rehabilitating programs.

Although there are different ways of writing down the goals, there is some common content that every functional goal should include (Jung, 2007): (1) the name of the person that the goal is written for; (2) an action verb; (3) the place where it will be carried out; (4) reasons that justify it; (5) strategies or actions to be carried to reach the goal, which should point at what will be done, who, how (method and/or technique), where, and in which routines; and (6) a criterion that will be used as an indicator to establish whether the expected goals have been achieved.

The ISFP has to include goals for the child, but also goals for the other family members. In the intervention, the professionals have to meet the parents' priorities concerning their child, but also offer support for the concerns of the nuclear family.

3rd step: Developing the Individualized Family Service Plan

The core element of the family-centered model is the IFSP, which is consensually developed between the family and the ECI center. McGonigel, Kaufman, and Jonhson (1991) defined the IFSP as an important agreement for the children and families, where the strengths will be recognized and constructed, beliefs and values respected, decisions honored, and expectations and aspirations promoted and allowed.

The IFSP collects, on the one hand, information given by the family through the aforementioned instruments (RBI, MEISR, ECOMAP), and, on the other hand, the observation and assessment of the child's development in different areas. As a result, the goals that we want to achieve, together with the activities and strategies to carry out to achieve them, will be detailed, planned and agreed with the family, always considering their needs. We should also establish the intervention proposals, as well as the supports and formal and informal resources that may be needed.

Therefore, the purpose of every IFSP is to work as a compass throughout the process, with the aim of empowering families so that, through their strengths, supports, and routines, they can meet their needs.

In the implementation of the Individuals with Disabilities Education Act - IDEA (2004), which established the special education and early intervention services in **the** USA, there are 8 essential elements to develop the IFSP:

1. To know the child's, or toddler's, current levels of physical, cognitive, communication, social or emotional, and adaptive development, on the basis of objective criteria.
2. To inform about the family's resources, priorities, and concerns to promote their child's development.
3. To reflect the measurable or expected results for the toddler, child, and family, including the child's current

development, as well as the criteria, procedures, and terms used to determine to what extent we are advancing towards achieving the goals, and the modifications or revisions of the outcomes.

4. To specify the specific evidence-based early intervention services needed to meet the unique needs of the toddler or child and the family, including the frequency, extension, and method for service provision.
5. To give importance to the natural environments that the early intervention services will be provided in.
6. To include planned dates for the beginning of service provision, as well as their scope, length, and frequency.
7. To identify the professional of reference for the toddler or child and family, who will be responsible for carrying out the plan and coordinating with other agencies and people, including transition services.
8. To establish steps to be followed to support the child's transition to other appropriate services.

The objectives collected in the IFSP and the kind of intervention have to include the characteristics of the families, their needs, and expectations. As observed by Guralnick (2001), we have to move towards a more comprehensive model, where parents are effective collaborators, participating in the development, establishment of goals, and in the intervention process. Undoubtedly, this is the greatest challenge of this model, as it implies a change of paradigm, because the intervention is centered on the collaboration, participation, and involvement between the professionals in early intervention centers and the families, with the aim of promoting their empowerment and making decisions that affect the entire process so that they can be shared and jointly signed by both parties in the IFSP.

4th step: Individualized Family Service Plan follow-up

Once the IFSP is written down, it is essential to determine and agree, between the professional and the family, the process to be followed from that moment to follow up the families' actions to apply the strategies described collaboratively in order to promote the development of goals agreed and prioritized in the IFSP.

Consistent with the FCM, the interventions proposed in the IFSP are expected to be carried out in the child's natural environment, which chiefly is the family context. Nevertheless, in some cases this may not be possible, and they may be carried out in the ECi centers totally or partially; although the context where the intervention is carried out is important, as stated by Dunst, Bruder, and Espe-Sherwindt (2014), the difficulties that may arise to work at the family's home should not be considered as an insurmountable obstacle; also working in the ECI centers, the FCM can be adopted. In any case, the ideal scenario would be the professional visiting the family once a week, at most once a fortnight, which enhances the appropriate follow-up of the

IFSP. However, flexibility should be a priority according to the possibilities of every particular family.

Thus, the IFSP implementation will be followed up through two complementary procedures. One has to do with the revision of goals established in the IFSP, and the other at the end of every follow-up session. The first will be carried out periodically, respecting times agreed for every goal as established in the IFSP, and the second in every meeting between the family and the professional.

It is essential to collect the most relevant information of every meeting. For this purpose, a template has been designed about aspects concerning the family and the child. Particularly, this template includes sections that have to do with: the most significant information since their last visit; IFSP goals dealt with in the meeting; activities carried out in the session; possible modifications in goals and/or strategies, and aspects pending for the next meeting. All this collected information is valuable material to know the process that both the child and family follow, as well as to assess, if appropriate, the need to introduce some modifications for the initial proposals.

As mentioned before, the IFSP is developed on the basis of the priorities that the family poses in the RBI. These needs arise from a temporary situation particular to the moment of the child's development and the specific conditions of the family context, which makes it quite expectable that during the time needed to implement the IFSP, between six months and a year, there are changes that will require adjustments in some aspects. When this happens, a short document can be written including the new goal or priority, together with the description of the strategies agreed to reach the new proposal. This document, with the corresponding date and signed by both the family and the professional, is attached to the IFSP as an annex. This procedure can be repeated as many times as necessary throughout the IFSP implementation. Once the expected time for the IFSP is over, which may be one year, it is the appropriate time for its revision. Usually, this revision leads to designing a new IFSP on the basis of the needs of the moment for the family and the child as identified in a new RBI.

In IFSP follow-up sessions, we assess the child's progress mainly resulting from professional-guided family interventions. This assessment is based on the observable behaviors related to the goals established in the IFSP; for this purpose, it can be useful to use the Goal Attainment Scaling (GAS), which is a scale to assess goals and monitor the process and can be the basis for the professional's progress assessment (Roach & Elliot, 2005).

In the follow-up stage, at the beginning of every family session, the professional should remember the goals established in the IFSP so that it is the family themselves who suggest where to begin to work; if the family finds it difficult to express this, it is important that the professional pays attention to the family's verbalizations during the session in order to identify the goals that the family wants to give priority to.

During IFSP follow-up, the professional has to think about their way of acting and intervening, particularly as long as they are not fully familiar with the FCM, as they may forget their role, at some point, and adopt practices more particular to the expert model. In this same respect, it is advisable to understand this reflection as a strategy that allows the professional to know their own perception of their professional competence, acting to make the family more and more secure and confident when making decisions and carrying out actions. Moreover, the professional has to remember that, to share their doubts concerning their work with the family, they have support from their ECI specialists and from the entire team; together they can solve doubts concerning a certain need or demand and thus improve their family care by applying the FCM appropriately.

Furthermore, throughout IFSP follow-up, the professional has the chance to grasp the family's perception of their own strengths to achieve the goals, as well as to identify the value that the family gives to the work carried out in the natural context and family-centered. This knowledge will allow the professional to have an impact on the kind of intervention to implement with the family, by offering examples and models. Besides, it is essential for the professional to put an emphasis and reinforce the good practices of the family; in this way, the family will acquire new strategies and greater confidence in their skills. Professionals have to remember that one of their responsibilities is to provide families with emotional, material support, and information (McWilliam & Scott, 2001). This can only be possible if professionals have the following qualities: positiveness, responsiveness, orientation for the family, sensitivity, and friendliness (McWilliam, Tocci, & Harbin, 1998). We should not forget that intervening as a professional in this model involves listening to the families as much as talking to them.

In the FCM, the professionals leave their role as experts aside and become a collaborator, whose main goal is to make families feel capable and competent. The goal of the professional has to be to empower the family, which makes them more autonomous and less dependent on professionals.

5ᵗʰ step: Home care

Following the recommendations on Good Practices in Early Intervention (DEC, 2014), after the development and acceptance of the IFSP, the intervention starts in the natural environments. The collaboration between the professional and families is key to provide the quality of family-centered care and, if possible, this care has to be provided in the child's natural environments in order to make learning general (Dunst, Trivette et al., 2001).

The interventions carried out in the child's usual contexts enhance the family's collaboration, and they do not perceive them as sessions to be added to their daily life (Trivette, Dunst, Boyd, & Hamby, 1995). Adopting participatory practices within natural contexts implies greater competence and

confidence of the family in their child's development (Dunst et al., 2014).

Home visits are the most coherent practice in early intervention services that follow the family-centered model. McWilliam (2010b) defined them as a meeting between the professional and the family in a usual place for the child, such as their home or another community context.

Home visits should not be confused with a simple change of physical space to carry out therapeutic activities. Professionals should not bring their materials to the family home; as Dunst (2001) observed, if we devote time to the "toy bag" we would be missing the opportunities to learn that the child has throughout the day, with their toys, with their family, and in their context.

The professional's intervention in the context is aimed at structuring strategies and helping the family to implement them within their routines in order to enhance the child's participation (Dunst, Trivette et al., 2001). It is not to ask parents to act as therapists, but to take advantage of the child's and the family's daily routines without having to find materials or exercises requiring extra family time as if it was another clinical session (Woods, Wilcox, Friedman, & Murch, 2011).

In the home visits, the family acquires functions of direct involvement with their child's development, transmitting their daily concerns to the professional of reference and making decisions about the appropriate routine and moment to implement the strategies.

Although home visits are the most usual practice, the setting of the intervention may include any place where the family engages in their routines, such as a park or the supermarket (Keilty, 2008). In general, in an intervention in natural contexts, the following phases can be distinguished:

- Presentation or preparation of what to do. According to the goals established, routines and places where the supports will be provided are set up.
- Discussion and observation. The professional collects information about what happens before, during and after the routine where the strategies will be established. It is not always possible to observe the routine; then the family is asked to describe the routine in detail or even to record it.

Looking for solutions. It is the moment to provide strategies to solve problems. To the professional's more technical contributions, we should add the family's knowledge of their child, the person to put it into practice and the moment of the day.

- Practicing strategies and reflecting. In most occasions, families ask for a demonstration on how to implement the strategy. This is what is called 'modeling', the moment when the professional carries out the strategy directly with the child so that the carers can visualize and put it into practice later. A fundamental part is that the professional has to observe the family while they are carrying out the strategy. This information will allow them

to improve it in order to have a more beneficial impact on the child's development.
- Planning, programming, and concluding. The family, together with the professional, decides the strategies to be implemented during the week until the professional's next visit. They are strategies that they have learned to put into practice with the professional's help and that they can go on using as part of their routines when the professional is not present. In general, visits are usually weekly, but we have to consider that it may vary if so decided by the family and the professional.

To conclude, we can state that the interventions in natural contexts promote the family's empowerment, by making them capable to meet their child's needs and promote their development during the daily activities and routines, and to achieve a better family quality of life.

A last reflection: The tradition in our country shows that almost all interventions are carried out in the CDIAT facilities; we could conclude that it is impossible to adopt the FCM as it does not seem easy to carry out an intervention at home. But we should consider that the really critical thing, rather than the setting, is the model of intervention, that is, assuming FCM principles and practices. While we advance in organizational changes and in the mind frameworks needed to move these working sessions to the family's home, we can undoubtedly transform our professional practices in this direction.

6th step: IFSP assessment and modification.

As stated in IDEA (2004), the IFSP implementation should imply its continuous assessment with the aim of making necessary adjustments and modifications. As a result, one of the points that every IFSP should include is the expected time to revise it. This date has to be necessarily flexible, depending on the scope of proposed goals. Nevertheless, 6 months seem to be the desirable period of time to implement the IFSP, which will make it reasonable to carry out its revision after these 6 months. This revision will mainly be the assessment of progress achieved, as well as an update on the concerns and needs of the family.

Progress assessment involves assessing which goals have been achieved totally or partially, which are in process and, even, which have not been achieved or have not been worked on. This assessment will encourage the proposal of new goals for the intervention in the next months.

Sharing the goals achieved with the family will firstly lead to the satisfaction of the success achieved and will decidedly contribute to increase their sense of competence, self-esteem, and confidence in their own possibilities and strengths; secondly, it will enhance the parents' greater sensitivity about their child's capacities and progresses, strengthening their main role as protagonists, their motivation and adherence to the program and, finally, it will contribute to the family's process of empowerment.

With regard to goals that have not been achieved or have not been worked on, as well as those that have been partially achieved or are in the process, we should reflect together with the family about them and the intervention strategies. We should ask: was the goal well planned?, was it realistic?, was it adjusted to the child's evolutionary moment?, was it really functional?, has it been possible to carry out the agreed strategies?, what problems have arisen that may have interfered with the program's development?, perhaps the goal was not a real priority for the family?, etc. The answer to these and other questions will guide the decision-making process: should we keep the same goal in the next IFSP?, is it adjusted in its scope?, should strategies be modified?, should it be replaced with another goal?, etc. This process, open and flexible, reinforces the collaborative work (family-professionals), contributes to making carers take on more responsibility and share it with professionals, and promotes their active participation: all of these fundamental aspects of family-centered work.

However, goal assessment is not enough to guide the modification of the IFSP. It is also advisable to revise the ecomap and the RBI in order to update the concerns and needs of the family. Revising the ecomap will allow us to determine whether the family's support network stays the same or there have been changes that may be significant for the new IFSP. It may be the case that the family has now more supports or resources. For instance, the child has started school and now has the figure of the teacher, or the grandparents have moved closer to the family and now they can be counted on. Of course, it could also happen that the family cannot count on some significant support anymore. For instance, that aunt that used to offer logistic support now has her own baby and cannot offer the same kind of help as before, or the family has moved away and do not have the support from their previous helpful neighbor.

In short, having an updated ecomap is essential to adjust the new IFSP to the family's new reality. This revision is easy and quick, as it is not necessary to construct a new ecomap, but we only have to share the old one and determine whether to add or delete supports.

Together with revising the ecomap, the family's routines should be revised too. On this occasion, the interview may be shorter, as we will only revise those routines that are happening in a different way in comparison to the first interview, as well as the new routines or activities that the child or the family did not use to do before. As can be expected, during the 6 months of IFSP implementation, there may have been significant changes. For instance, the child may have started school, a new sibling may have been born, a parent may have changed job and working hours, that helpful grandparent may have died, etc. We can clearly imagine that these changes will substantially modify the child's and the family's routines, and so new concerns and needs may arise.

Some of these changes may have been foreseen in advance by the team (professionals and family), so the time for

the IFSP revision can coincide with these changes. However, other changes may have appeared unexpectedly, and so should be noted when carrying out the 6-month revision or even before, if necessary.

Therefore, the assessment and modification of the IFSP can take place at different moments:

- In general, the revision will take place at the expected time, which will usually be after 6 months. On occasions, a shorter or longer period can be planned, making it coincide with some significant change in the family routine. For instance, it is common to make the IFSP revision coincide with the child's starting school.

- On other occasions, it may be necessary to revise the IFSP before the planned time due to some unexpected and very significant change in the family routine. For instance, a family member gets seriously ill and needs periods in hospital and time for cure and treatment processes. Obviously, in front of important changes in family routines, it is usual for concerns and needs to be modified, as well as their prioritization.

- And finally, although not very usual, the IFSP may have to be revised and modified before the expected time because goals have been achieved much quicker than expected. On occasions, thanks to the family's active involvement, progresses are achieved quickly and soon the planned IFSP is not enough. Logically, it is advisable to prepare the IFSP with a reasonable timing and appropriate planning to avoid constant revision, although the feeling of self-efficacy and satisfaction of the family when they achieve IFSP goals is remarkable.

Final Considerations

Throughout this paper, we have defined what is understood by FCM both from the scientific community and professional practice, and have described the steps that make up an intervention proposal, examining in each of them the most frequent questions to make appropriate decisions. Undoubtedly, the question that could arise at this moment would have to do with the evidence available in scientific literature regarding the effectiveness of FCM and, if so, what aspects seem to be more relevant. We will devote this last section to this purpose, briefly though, as this is not the main purpose of this paper.

The results of this research show, firstly, that the professionals participating in the study considered the FCM of great value for their work with children and families, as it allows them to better know the day-to-day of families, their strengths, and concerns, as well as to establish a different relationship, of a collaborative nature and more sensitive to their needs. Then, the participating families perceive that the FCM allows them to be more capable (empowerment) in front of their child's needs and positively assess the fact of focusing on daily routines in their life contexts in order to promote their child's development and, in this respect, home visits are very helpful (Gràcia et al., *in press*). Moreover, participants pointed to the need for more knowledge about the philosophy and strategies of this approach, as well as the opportunity to have meetings with other professionals and exchange sessions with families as a training method in order to implement the new FCM more confidently and efficiently in the future (Vilaseca et al., *in press*).

There are many studies showing that family-centered practices are strongly linked to benefits both for parents and for children and the family as a whole in terms of family outcomes Dunst, Hamby, & Brookfield, 2007; Case-Smith, 2013; Espe-Sherwindt, 2008; Rosenbaum, King, Law, King, & Evans, 1998; Stallard & Hutchinson, 1995). Trivettte and Dunst (2000) and Trivette, Dunst and Humby (2010) identified seventeen evidence-based family-centered practices and grouped them into four categories: (1) Families and professionals share responsibilities and work collaboratively in order to share expert knowledge so that families can make informed decisions; (2) practices strengthen the family's functioning as supports allow families to take advantage of not only formal but informal supports to lead the life that they want; (3) practices are flexible and adjusted to the needs, values, and beliefs of the families; and (4) practices mobilize the strengths of the families in order to take advantage of their daily routines.

Trivette et al. (2010) stated that results show that FCM practices aimed at promoting parental competences (empowerment) have a direct effect on the parents' beliefs about their self-efficacy and well-being; and indirect effects on the improvement of the parents' interactions with their child, generating as a result more and better opportunities for their development. In this same respect, Trivette and Dunst (2009) observed that the family-centered approach, rather than the professional-centered approach, helps parents to be more capable and competent to promote their child's development as it improves the family functioning, promotes some specific competences, confidence in their possibilities and their satisfaction.

Likewise, Case-Smith (2013) informed about the possible positive consequences on the family and the child. The systematic review on FCM-based interventions allows us to conclude a positive impact on the social and emotional development of children aged 0 to 5 years. Particularly, (1) it promotes positive relationships between the rearing figure and the child; (2) it promotes joint care; (3) it promotes the child's greater involvement in peer relationships; and (4) this parents' accompaniment generates specific strategies to promote positive interactions.

Moreover, Swanson, Raab, and Dunst (2011) observed that the FCM in early intervention promotes the capacities and confidence of parents to provide children with the learning opportunities that have a positive impact on their development. These authors conceptualized the family's capacities as the combination of practical skills and efficacy beliefs that allow them to carry out their parenting functions.

Espe-Sherwindt (2008) observed that, among the evidence of the benefits of FCM use, there is a feeling that

things are being done better and greater confidence in their own possibilities; both aspects have a positive influence on their child's development. In short, greater psychological well-being and satisfaction with services received (Rosenbaum et al., 1998). Among the benefits of FCM, we can also point at greater responsibility of carers (Trivette, 2003), greater sensitivity to the child's competences (Dunst, & Kassow, 2007), and the establishment of a safer bond (Kassow, & Dunst, 2007).

Finally, the degree of family participation in the programs is a clear indicator of the FCM success (Gallagher, Rhodes, & Darling, 2004; McCracken, & Baglin, 2000; McWilliam, Snyder, Harbin, Porter, & Munn, 2000). Active family participation is essential to be more efficient in their supports and services received, and ultimately to achieve a better quality of life for all the family members (Verdugo, Schalock, Keith, & Stancliffe, 2005).

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