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Early Childhood Intervention practices in the southeast of Spain: professionals and families perspective

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Título: Prácticas de Atención Temprana en el Sureste de España: Perspectiva de Profesionales y Familias.
Resumen: Actualmente en España estamos viviendo un proceso de transformación en Atención Temprana hacia un modelo centrado en la familia. Ésta empieza a cobrar un especial protagonismo como eje fundamental de la intervención, participando activamente en el proceso educativo y rehabilitador del niño.
La evidencia científica señala que la adecuada interacción del profesional con la familia, a través de la implementación de prácticas relacionales y participativas, es fundamental para el éxito de la intervención. Por ello, resulta interesante conocer cómo se realizan esas interacciones y cómo son percibidas por los dos agentes.
Se aplicó el cuestionario de Estilos de Interacción entre Padres y Profesionales en Atención Temprana (EIPPAT) (Escorcia, García-Sánchez, Sánchez-López & Hernández-Pérez, 2016) para analizar las estrategias y estilos de interacción de los profesionales con las familias. El cuestionario fue cumplimentado por 504 familias y 187 profesionales. Los resultados demuestran que los profesionales españoles desarrollan más prácticas relacionales y menos prácticas participativas con las familias. Sin embargo, creen que hacen más prácticas participativas de las que las familias realmente reciben, según la percepción de estas familias. Se concluye sobre la necesidad de mejorar la formación del profesional en las implicaciones de las prácticas centradas en la familia en Atención Temprana.
Palabras clave: Atención Temprana; Prácticas centradas en la familia; relaciones profesionales – familias; prácticas relacionales; prácticas participativas.

Abstract: Currently in Spain we are living a process of transformation in Early childhood intervention towards a model centred on the family. This model begins to take on a special role as the fundamental axis of the intervention, participating actively in the educational and rehabilitation process of the child.
Scientific evidence shows that suitable interaction of professionals with the family, through the implementation of relational and participatory practices, is fundamental for the success of the intervention. Therefore, it is crucial to know how these interactions are carried out and how they are perceived by them.
The Styles Questionnaire of Interaction between Parents and Professionals in Early Intervention (SIPPEI) (Escorcia-Mora, García-Sánchez, Sánchez-López & Hernández-Pérez, 2016) was applied in order to analyze the strategies and styles of interaction of professionals with families. The questionnaire was completed by 504 families and 187 professionals.
The results obtained show that Spanish professionals develop more relational practices and less participatory practices with families. However, professionals believe that they do more participatory practices than families actually receive, from the perception of these families. This leads us to conclude, about the need to improve professional training about the implications of family-centred practices in Early Intervention.
Keywords: Early intervention; Practices focused on the family; professional-families relationships; relational practices; participatory practices.

Introduction

Early Intervention (EI) in Spain is a relatively young discipline. EI started its activities in the 70s, as a purely rehabilitative intervention focused on the child (Giné, García-Dié, Gràcia & Vilaseca, 2005). In the year 2000, a group of professionals from different disciplines and regions of Spain published, with institutional support, the White Book of the EI (GAT, 2000). This book contains basic principles and unifies criteria in order to facilitate higher quality care. The document assumes the importance of the family and defends that all actions and interventions must consider not only the child, but also the family and its environment. It advocates for close collaboration of social, health and educational services and for the implementation of primary, secondary and tertiary prevention actions in relation to the care of children with EI needs (GAT, 2000). However, it defends the importance of Child Development Centres and EI, to which the child should go on an outpatient basis to receive treatments.

The work philosophy proposed by the White Book of the EI is applied in different ways in each Autonomic Community of the country. This is due to the lack of specific and unique state regulations of the Spanish government. According to the study carried out by the same group that published the White Book, ten years after its publication, important differences are observed in the implementation of EI at national level. There are big differences in the professionals that are part of the teams; times of intervention directed to the child, family and environment, or they are not even always contemplated; differences in the compartmentalization of resources; autonomy of the centres; and availability of resources, especially in rural areas (GAT, 2011). In most of the services the intervention continues focused on the child, organized as outpatient sessions, although there may be a greater or lesser effort on orienting the families. Statistics of this study show, that, in average, 65.88 % of the intervention time is dedicated to the child; only 13 % is directed to the family and even less than 4.83 % to other environments.

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This organization of the EI in Spain is in accordance with what we found in other European countries. A study about the situation of the EI in 19 European countries, reflected differences conditioned by the socioeconomic and cultural characteristics of the different countries. (European Agency for Development in Special Needs Education, 2005). For example, EI was offered to children up to 3 or 6 years old, depending on the age of beginning of the compulsory education. In most of the countries, direct attention was given to the child. Support for the family was an intervention on a secondary level, with the exception of Portugal and England, which declared prioritizing work with the family. Similarities were also found in some aspects. For example, all countries highlighted that parents could choose the centre to attend. However, in practice, the possibility of choice ended up being very limited due to the limited availability of vacancies and the tendency to centralize services in metropolitan areas, in decrement of rural ones.

Professional teams are of a multidisciplinary nature in all countries and the coordination and participation of health and education services usually fails.

The same European agency, five years later, conducted a follow-up study of EI practices (European Agency for Development in Special Needs Education, 2010). Advances were found in the implementation of family-centred practices in some countries such as Germany, England or Norway. In these countries, it was appreciated that work with parents had become more active. Families were involved in making decisions related with their children, observing improvements in information and counselling practices for families, training of the parents, participation in sessions focused on children, consensus on intervention objectives, etc. However, the report also reflects that in many countries, it is still necessary to continue raising awareness among professionals in order to involve parents more actively in the EI process (European Agency for Development in Special Needs Education, 2010). Spain is one of those countries where it is still necessary to improve in this aspect. An appreciation in which publications both inside and outside of Spain coincide (Castellanos, García Sánchez, Mendieta, Gómez López & Rico, 2003, García-Sánchez, 2002, García-Sánchez, Escorcia-Mora, Sánchez-López, Orcajada & Hernández-Pérez, 2014, Gine, Gràcia, Vilaseca & García-Díe, 2006, Giné, Balcells & Mas, 2010, Gutiez, 2010, Perpiñan, 2009).

Nowadays, international organizations such as the World Health Organization (WHO, 2012), the United Nations Educational, Scientific and Cultural Organization (UNESCO, 2015), the Division for Early Childhood of the Council for Exceptional Children (DEC, 2014), as specialized professional associations such as the European Association on Early Childhood Intervention (http://www.eurlyaid.eu) and the International Society on Early Intervention (http://depts.washington.edu/isei/), make a unanimously call to incorporate evidence-based and family-focused practices in EI. Practices that help improve the quality of life of families with children with disabilities. They consider that it is necessary to provide integrated interventions, supports and special services, always using models of consultation and collaboration between professionals and families (Jayaraman, Marvin, Knoche & Bainter, 2015).

There is no doubt that in order to develop an EI family-centred practices, a close relationship should be established between the members of the child-family-professional triad. The quality of the intervention will be clearly affected by the quality of the relationships that are established. Meta-analysis carried out by Dunts, Triviette & Hamby (2007), in which presence of two types of indicators in the EI professional practices, was evaluated: a) relational, which include behaviours associated with good clinical practice (compassion, empathy and active listening, etc.) and with the functions of the professional in the acquisition of competences, strengths and capabilities of the members of the family and b) participatory, where practices aimed at encouraging participation of family members in decision-making are contemplated; the use of their own skills and the development of new skills to obtain the desired resources; and collaboration with the professional as basis to enable skills and capabilities in the family. These two indicators will undoubtedly mark the whole process of intervention and its success.

In the same way, numerous studies have highlighted the importance of the relationships established between parents and professionals (Bailey, Raspa & Fox, 2012, Blue-Banning, Summer, Frankland, Nelson & Beegle, 2004, Dunst, 2000, 2005, 2006, Dunst & Triviette, 2009, Guralnick, 2005, 2011, MacKean Thurston & Scott, 2005, Mahoney & Nam, 2011, Pretis, 2005, 2012, Turnbull, Turnbull & Kyzar, 2009, among others). All of them highlight a series of aspects and principles that must be taken into account, when establishing positive relationships that facilitate intervention processes. Turnbull et al. (2009), for example, taking up results from the Blue-Banning et al. (2004) study, summarizes a series of elements that should be present in the cooperation agreements between parents and professionals: professional skills, communication, respect, commitment, equity and trust.

It is appropriate to highlight that communication plays a fundamental role in the construction of effective collaboration and the establishment of relationships between professionals and families. This communication is characterized by openness, relevance, effective use of silence and an ability to adapt to meet the needs of the other (Friend & Cook, 2010). The way in which information is transmitted also influences it. According to McWilliam (2012), communication is a reciprocal and transactional process, of conversational interaction, in which both the speaker and the listener send and receive messages through verbal and non-verbal means.

In Spain, in the last five years, actions are being initiated to incorporate practices centered on the family in EI. Thus, it is interesting to know how the different agents involved are really interacting, to what extent relational and participatory practices are being carried out, and how the information is being transmitted to the family. Answering these questions

will help us to understand how professional practices are developing and to identify possibilities for improvement.

Recently, a questionnaire on styles of interaction between parents and professionals in EI (EIPPAT) (Escorcia-Mora, García-Sánchez, Sánchez-López and Hernández-Pérez, 2016) has been developed in Spain. It is an instrument designed to identify the degree of implementation of different actions, practices and interaction styles, carried out by the EI professional to guide families (relational and participatory practices). In the present study, we present the results of its application in the southeastern regions of Spain

Methods

Participants

A total of 504 families and 187 professionals participated in the study, voluntarily and anonymously. Both groups came from 28 EI centers in the Autonomous Communities of Valencia and Murcia, located in the SE of Spain.

The 504 main caregivers had an average age of 36.46 years (*SD* = 5.72), 100 were men (19.8%) and 404 women (80.2%). The majority were mothers 392, (77.8%), although 100 parents (19.8%) and 8 grandmothers (1.6%) also participated. Its sociodemographic characteristics are detailed in Table 1. The characteristics of the children with TA needs that these primary caregivers were in charge of are summarized in Table 2.

Table 1. Sociodemographic characteristics of the main caregivers.

Characteristics		*N*	%
Gender	male	100	19.8
	female	404	80.2
Age	17-30	50	9.9
	31-40	347	68.8
	41-50	70	13.9
	51-71	7	1.4
	Not defined	30	6.0
	M (SD)	36.46 (5.72)	
Relationship with the child	Mother	392	77.8
	Father	100	19.8
	Grandmother	8	1.6
	Others	4	.8
Studies	Without studies	13	2.6
	Primary education	136	27.1
	Secondary education	113	22.5
	Higher education	76	15.1
	University education	164	32.7
Employment	With employment	234	47.6
	Unemployed	147	29.3
	Housewife	84	16.7
	Students	6	1.2
	Retired	4	.5
	Other tasks	22	4.4
Marital status	married/couples	428	85.3
	Separated/Divorced	28	5.6
	Widows	2	.4
	Single	44	8.8

Table 2. Sociodemographic characteristics of children whose families participated in the study.

Characteristics		*N*	%
Gender	Male	340	67.5
	Female	164	32.5
Age (months)	0–12	24	4.8
	13–24	78	15.6
	25–36	141	28.2
	37–48	135	27.0
	≥ 49	126	24.4
Time spent in EI (months)	≤ 6	132	26.2
	7–12	113	22.4
	13–24	136	27.0
	25–36	80	15.9
	≥ 37	34	6.7
	Not specified	9	1.8
	M (SD)	18.54 (15.19)	
Number of siblings	Only child	192	39.8
	1 sibling	175	36.2
	2 siblings	86	17.8
	3 or more	30	6.2
	Eldest child	246	55.2
Difficulties / Problems	Language & communication	381	75.6
	Social relationships	117	23.2
	Motor skills problems	204	40.5
	Risk factors	30	6.0
	Sensorial problems	52	10.4
	Intellectual problems	139	27.6
	Other difficulties	139	27.6

187 EI professionals participated in the study. They had an average age of 36.9 years and a professional experience range between 2 and 12 years in 68.5% of the cases. 74.3% of these professionals were women and 70.7% had master studies or specialization in EI. Other sociodemographic details of these professionals are summarized in Table 3.

Table 3. Sociodemographic characteristics of Early Intervention professionals.

Characteristics		Frequency	Percentage
Gender	Male	5	2.67%
	Female	139	74.3%
	Not identified	43	22.99
Average Age *(SD)*		36.9 (9.0)	
Professional profile	Stimulation	60	32.4 %
	Speech therapy	22	11.9%
	Psychology	34	18.4%
	Pedagogy	11	5.9%
	Physiotherapy	31	16.8%
	Occupational therapy	14	7.6%
	Psychomotor function	11	5.9%
	Others	11	5.9%
	Not specified	2	1.1%
Experience (years)	Up to 2	25	13.6%
	Between 2-6	59	32.1%
	Between 7-12	67	36.4%
	Between 13-18	17	9.2%
	More than 18	16	8.7%
	Not specified	3	

Procedure

We contacted by postal mail with the Technical Direction of each service, asking their collaboration for the study. The objectives of the study were informed; questionnaires and instructions for their completion were presented. After that, a follow-up was done by mail and telephone to solve doubts and facilitate participation.

The directors of each centre were in charge of delivering questionnaires to service professionals, centralizing the collection of questionnaires and sending them to the research team. On their behalf, each professional offered families the opportunity to participate in the study. Families that wanted to participate filled in the questionnaire and returned it in a sealed envelope.

Data analysis

The data were analysed both descriptively, through the analysis of means and standard deviations, and inferential. For the analysis of differences between means the t-Student test was used for independent samples, the Cohen d statistic was calculated to determine the size of the effect. The SPSS program, version 20.0, was used for the statistical analysis of the data.

Instrument

The Styles Questionnaire of Interaction between Parents and Professionals in Early Intervention (SIPPEI), in both versions (primary caregiver and professional), was designed specifically for research. For its design, a rigorous process was followed in which focal discussion groups, expert judgment and a pilot application of the instrument were used. All this, for the preparation of different items, its purification and content validation. (Escorcia eta al., 2016).

It consists of 42 items with five response options linked to a time criterion (1-*Never, 2-Almost never, 3-Sometimes, 4-Almost always, 5-Always*) and two open items. These items assess four dimensions on the relationships established between professionals and family in EI: (I) Actions carried out to give orientations (8 items plus 1 open); (II) Difficulties to follow the guidelines (7 items plus 1 open); (III) Personal style of the professional when giving orientations (14 items); and (IV) Orientations for training (11 items).

It also collects sociodemographic identification data of the main caregiver (sex, age, kinship with the child, level of studies, occupation, marital status, nationality and mother tongue), of the child (age, gender, number of siblings, place that occupies in the family, treatments that receives, difficulties and time that has been attending the centre), and about the professional (sex, specialty that exercises in the EI centre, years of experience, completion of specialization studies, performance of some position of responsibility, management or organization).

Results

We present the results of the SIPPEI Questionnaire comparing the responses of the two agents involved: families and professionals of EI.

Table 4 shows the means and standard deviations of the items in Dimension I (actions taken to give orientations), according to the opinions of families and professionals. It also shows results of the student's t test for differences between independent means and Cohen's d statistic to assess the size of.effect. The exact wording of the items in the two versions of the SIPPEI questionnaire can be found in Escorcia et al. (2016).

Table 4. Descriptive statistics, test t and d of Cohen in the items of the dimension I (actions carried out to give orientations) according to opinions of families and professionals surveyed.

Items	Groups	*N*	*M*	*SD*	*t*	*dg*	*p*	*d*
1. Written recommendations	Families	463	3.17	1.41	-4.38	353	<.001	-.26
	Practitioners	146	3.62	.96				
2. Oral recommendations	Families	469	4.47	.87	-2.40	336	.017	-.14
	Practitioners	146	4.63	.62				
3. Family presence in the sessions to see activities	Families	461	2.58	1.50	-12.54	365	<.001	-.75
	Practitioners	144	3.93	.99				
4. Family presence in the sessions to repeat activities	Families	455	2.08	1.28	-17.17	288	<.001	-1.03
	Practitioners	146	3.92	1.07				
5. Practitioner home visits and guidance insitu to the family	Families	461	1.41	1.11	-3.45	247	.001	-.21
	Practitioners	145	1.77	1.08				
6. Practitioner home visits to serve insitu as a rolemodel	Families	453	1.48	1.19	-2.4	595	.018	-.23
	Practitioners	144	1.74	1.03				
7. Practitioner suggestions of times and routines to follow guidance	Families	459	3.76	1.23	-4.24	320	<.001	-.26
	Practitioners	146	4.17	.93				
8. Discussing video recordings with the child	Families	444	1.66	1.24	-9.45	289	<.001	-.58
	Practitioners	144	2.65	1.03				

According to families and professionals, the most common practices are, in this order, to give oral recommendations (item 2), suggest times of day and routines in which to implement the guidelines (item 7) and give written recommendations (item 1). The least frequent (*never* or *almost never*) are home visits (items 5 and 6) and commenting on video recordings (item 8).

We found statistically significant differences in all the items of dimension I between the opinions of professionals and families. Always with higher valuations from professionals. We highlight the differences found in items 3, 4 and 8, where results of moderate and high magnitude are reached in the test for estimating the effect size. Families perceive a lower presence and participation in sessions (items 3 and 4) than that estimated by professionals. Families think that *almost never* and only *sometimes* (M = 2.58; SD = 1.50) professionals develop the session while they are present (item 3); whereas the professionals think that this *almost always* happens *(*M = 3.93; SD = 0.99). Likewise, professionals indicate that *almost always* (M = 3.92; SD = 1.07) invite families to do activities with the child within the intervention sessions, while families think that this *almost never* happens (M = 2.08; SD = 1.28) (item 4).

Something similar happens in item 8, which asks about the use of video as a resource to offer guidance to families. The professionals approach their average answer to the verbal label *sometimes* (M = 2.65; SD = 1.03), while families indicate that this *never* or *almost never* (M = 1.66; SD = 1.24) the professional uses video recordings to offer guidance.

In Table 5, the descriptive statistics, tests t and the Cohen d statistic are presented to assess the effect size of the items that make up the dimension II of the questionnaire, referring to the difficulties that families can encounter in order to follow the guidelines of the professionals.

Table 5. Descriptive statistics, test t and Cohen's d test in the items of dimension II (difficulties to follow the guidelines) according to opinions of families and professionals surveyed.

Items	Groups	*N*	*M*	*SD*	*t*	*dg*	*p*	*d*
10. Families' lack of time	Families	459	2.29	1.01	-10.21	319	<.001	-.62
	Practitioner	145	3.1	.76				
11. Carer tiredness	Families	461	1.85	.92	-13.24	302	<.001	-.79
	Practitioner	145	2.83	.73				
12. Child tiredness	Families	463	2.4	.89	-4.04	318	<.001	-.24
	Practitioner	146	2.68	.67				
13. Lack of physical space to practice the given guidance	Families	463	1.47	.84	-7.09	276	<.001	-.41
	Practitioner	143	1.97	.71				
14. Not knowing how to put in practice the practitioner recommendations	Families	449	1.68	.92	-12.39	332	<.001	-.75
	Practitioner	146	2.55	.68				
15. Not knowing how to integrate recommendations in routines	Families	449	2.39	1.32	-3.71	454	<.001	-.23
	Practitioner	143	2.71	.71				
16. Family not convinced of the importance of guidance	Families	446	1.42	1.02	-12.10	303	<.001	-.83
	Practitioner	145	2.55	.82				

The items of this dimension present average answers that are usually between the verbal labels of *never* or *almost never* in the families and reach *sometimes label* in professionals. The highest scores are reached by the items referred to "not knowing" by families, how to integrate the guidelines given in their daily routines (item 15), lack of time of families (item 10) or problems due to fatigue of the child (item 12).

Once again, we found statistically significant differences in all the items of this Dimension II of the questionnaire when comparing the values of families and professionals. Professionals are the ones who always score higher in all the items. The differences in the valuation of items 10, 11, 14 and 16 are especially marked, where moderate and high magnitude results were obtained in the effect size estimation test.

Professionals point out that it is the lack of time of the families (item 10) that - *sometimes* makes difficult to follow the guidelines (M = 3.10; SD = 0.76), while the families think that *almost never* this is a problem (M = 2.29; SD = 1.01).

The professionals estimate that *almost never* and *sometimes* families are not convinced of the importance of following the guidelines (item16) (M = 2.55; SD = 0.82), or lack of knowledge when putting into practice the recommendations of the professional (item 14) (M = 2.55; SD = 0.67). On the other hand, families express that this happens *never* or *almost never* in the two cases (M = 1.42; SD = 1.02) (item 16) and (M = 1.68; SD = 0.92) (item 14).

The professionals estimate that *sometimes* the fatigue of the families can be a difficulty to follow the orientations at home (item 11) (M = 2.83; SD = 0.73). On their behalf, families estimate that this difficulty *almost never* arises (M = 1.85; SD = 0.92).

Table 6 shows the results of the items in dimension III of the questionnaire, referring to the personal style of the professional to offer guidance to the family.

Table 6. Descriptive statistics, test t and Cohen's d test on items of dimension III (personal style of the professional when giving guidance) according to opinions of families and professionals surveyed.

Items	Groups	*N*	*M*	*SD*	*t*	*dg*	*p*	*d*
18. Respectful treatment	Families	466	4.98	.18	-1.81	465	.071	-.11
	Practitioners	146	5	0				
19. Understanding the language of therapist/family	Families	465	4.95	.30	9.55	152	<.001	.72
	Practitioners	144	4.21	.92				
20. Comprehensive explanations	Families	465	4.92	.29	3.54	194	<.001	.23
	Practitioners	146	4.79	.41				
21. Answering family doubts	Families	465	4.91	.35	2.05	229	.042	.07
	Practitioners	145	4.84	.37				
22. Availability to attend families	Families	465	4.94	.29	-.048	302	.966	-.03
	Practitioners	146	4.95	.23				
23. Time to attend families	Families	463	4.77	.52	7.63	212	<.001	.46
	Practitioners	146	4.34	.63				
24. Knowing family worries	Families	463	4.69	.57	3.47	237	.001	.21
	Practitioners	146	4.5	.59				
25. Speaking openly with practitioner without feeling judged	Families	464	4.9	.35	5.76	178	<.001	.38
	Practitioners	146	4.6	.59				
26. Generating trust in the family	Families	465	4.9	.36	2.20	232	.029	.13
	Practitioners	146	4.82	.38				
27. Listening to the family	Families	464	4.96	.20	1.45	198	.15	.11
	Practitioners	146	4.92	.27				
28. Understanding the family	Families	464	4.89	.36	4.32	204	<.001	.27
	Practitioners	146	4.71	.45				
29. Adapting to the child	Families	448	4.88	.42	4.38	201	<.001	.28
	Practitioners	146	4.66	.56				
30. Flexibility in home visits	Families	324	2.54	1.86	-0.44	279	.663	-.04
	Practitioners	133	2.62	1.63				
31. Taking into consideration family needs while suggesting intervention	Families	439	4.49	1.10	-0.35	434	.724	-.03
	Practitioners	146	4.52	.64				

In this dimension, the valuations that both agents offer in the items are very high (between *almost always* and *always*, with a clear tendency toward the verbal label *always*). The only item lower valued (between *almost never* and *sometimes*) is the one referred to the flexibility to organize home visits (item 30). The rest of the items have average scores that always remain above 4 points. Even so, the items with lower scores are those that take into account the needs of families when proposing the intervention (item 31) and to know their concerns (item 24).

Of the 14 items that constitute dimension III, nine are valued significantly higher by families than by professionals (items 19, 20, 21, 23, 24, 25, 26, 28 and 29). In items 19, 23 and 25 the magnitude of the effect size was moderate.

The greatest differences between the assessments of both agents are given in items 19 and 23. Item 19 refers to a specific problem of difficulties in understanding the language in families with a mother tongue different from that of the professional. Item 23 refers to the professional's time available to care families. Families tend to consider that professionals *always* have time to dedicate (M = 4.77; SD = 0.52), while professionals perform a somewhat lower assessment (M = 4.34; SD = 0.63).

Table 7 shows the descriptive statistics of the items that make up the IV dimension (guidelines for training), the student's t-test results for independent samples, and the Cohen's d statistic to assess the size effect.

Table 7. Descriptive statistics, test t and Cohen's d test in the items of dimension IV (guidelines for training) according to opinions of families and professionals surveyed.

Items	Groups	*N*	*M*	*SD*	*t*	*dg*	*p*	*d*
32. Helping families to understand problems and difficulties of child	Families	463	4.74	.54	.31	604	.755	.02
	Practitioner	143	4.73	.48				
33. Involving other members of the family or friends in the intervention	Families	445	3.6	.50	1.11	449	.266	.16
	Practitioner	142	3.49	.81				
34. Making families understand the child's improvement	Families	462	4.74	.60	-.36	603	.722	-.03
	Practitioner	143	4.76	.52				
35. Helping families to identify personal support	Families	451	4.42	1.02	2.34	591	.019	.15
	Practitioner	142	4.2	.80				
36. Discussing with the family intervention objectives	Families	464	4.65	.76	.04	541	.972	.00
	Practitioner	79	4.65	.53				
37. Guiding and supporting families in decision taking Guia	Families	454	4.5	.92	-1.04	338	.298	-.06

Items	Groups	*N*	*M*	*SD*	*t*	*dg*	*p*	*d*
38. Guiding families to search for resources	Practitioner	141	4.57	.64	1.91	593	.056	.19
	Families	453	4.39	1.03				
39. Encouraging families to learn strategies	Practitioner	142	4.2	.86	2.50	600	.013	.24
	Families	459	4.58	.77				
40. Showing interest in knowing if families follow guidance	Practitioner	143	4.4	.75	-.50	335	.62	-.02
	Families	460	4.55	.82				
41. Encouraging families to participate in parent or activity groups	Practitioner	143	4.58	.57	-7.02	545	<.001	-.45
	Families	443	3.63	1.52				
42. Facilitating materials and documents to the family in order to learn	Practitioner	142	4.26	.64	-1.07	363	.284	-.07
	Families	424	3.8	1.37				
	Practitioner	143	3.91	.93				

The items of this dimension also reach high average scores in the two agents surveyed, many of them between the verbal labels of *almost always* and *always*. Items with lower scores are referred to involving other members of the family or friends in the intervention (item 33) and to provide families with materials and documentation to learn (item 42).

We found statistically significant differences in the opinions of families and professionals in items 35, 39 and 41. In items 35 and 39, families valued more than professionals the help offered to identify personal supports and the spirit offered to learn strategies that help to improve the development of the child. The estimate of effect size for these items was of low magnitude. However, in item 41 it is the professionals who score higher, stating that *almost always* the professional helps families to participate in groups and meetings (M = 4.26; SD = 0.63), while families believe that this occurs in less degree *(*M = 3.63; SD = 1.52). The estimate of effect size for this item was of moderate magnitude.

Finally, it is important to point out the high abstention of the group of professionals when answering the item 36 referred to discuss the objectives of intervention with the family. Only 79 of the 187 professionals surveyed, answered this item, which is 42.3% of the sample.

Discussion

The volume of participants in our study has been very satisfactory and representative of the groups involved. Especially taking into account that the functioning of the EI services of the Autonomous Communities of Valencia and the Region of Murcia is representative of what happens in most of the national territory; that is, an EI organized through autonomous centres that program outpatient interventions for the development of treatment sessions with the child, in which they insert orientations for families, from a position of the professional as an expert (GAT, 2000, 2011).

When performing an analysis of the results obtained in each dimension, we found coincidences and discrepancies between families and professionals when evaluating the different items. Firstly, regarding information exchange practices (Dimension I), both families and professionals agree that offering therapeutic recommendations orally or written, is the most common practice for transmitting information, while home visits are less common, modelling activities and corrective feedback after viewing videos. According to these results, the exchange of information, which is one of the basic pillars of the EI intervention processes, is perhaps not being addressed in the most appropriate way from the perspective of family-centred practices, that, facilitate participation and involvement of parents and encourage their learning. Taken into account how adults learn, the activities that promote greater learning and favour family training are modeling, including feedback on interactions and using coaching strategies (Knowles, Holton & Swanson, 2005, Rush & Shelden, 2011). The simple transmission of recommendations at the oral level does not ensure that the caregiver understands and will be capable of applying them. More difficult will be to include them in their daily routines, thus professional should help main caregiver to reach them. (McWilliam, 2010).

Within dimension I, professionals rate highly, to suggest to main caregivers, the moments of the day and routines, in which to implement their recommendations. Despite this, there are no visits to the natural environment, that allow the analysis of that environment and its routines: both families and professionals, point out that *Never* or *almost never* the professional visits the home, or guides there, or performs activities at home to train the caregiver.

In this dimension I, the analysis of the scores given to items by families and professionals shows opposing experiences. According to professionals, they *almost always* develop modelling actions with main caregiver (development of session being the caregiver present and showing it so that caregiver can repeat the exercise). So the professionals understand, that they make a correct practice. These results are contrary to the answers in the questionnaire carried out by the families, who affirm that these practices are *almost never* carried out. This difference of opinion makes us think about a possible overvaluation by professionals of their own practical activities, perhaps due to a need to project a positive image of their work. Being aware of the limits that EI training plans currently have in our country, we can also think that there may be, in some professionals, lack of training in strategies to carry out a different practice.

When assessing the problems encountered by families to follow the guidelines offered (dimension II), professionals are always more pessimistic in their assessments and see more problems than the families themselves. These families

consider that difficulties such as lack of time, fatigue of the child and "not knowing" how to integrate the recommendations in the daily routine, are *almost never* or only sometimes. The professionals, on their side, consider that these problems are *more frequent*.

Once again, we see here the importance of applying the principles of family-centred services. Recall, for example, McWilliam (2010), when he talks about the importance of routines. If the professionals study family routines in depth, if they have the necessary time to know and help the families to analyse what happens in the house and in child's environment, together they would be able to plan intervention objectives fully adapted to these routines, so they would not have this kind of sensations. In addition, it would be expected to obtain greater participation of the main caregiver, which would favour their autonomy and an improvement of their competence for the spontaneous use of learning opportunities that occur at different times of the day, which is what is advocated in practices that follow a family-centred approach (Dunst, Raab, Trivette, & Swanson, 2012; Dunst & Swanson, 2006; Trivette, Dunst & Hamby, 2010).

It is striking too, the significant differences found when asking, whether the family's conviction about the importance of orientations is a problem for following them. Again, professionals show opinions that, on average, are between *Sometimes* and *Almost always*. Meanwhile, the answers of the main caregivers leave the average between *Never* or *Almost never*. Future investigations may attempt to elucidate whether parents are answering based on what they believe would be the desired response; or if professional's response is signalling a distrust of the possibilities on main caregivers (McBride, Brotherson, Joanning, Whiddon & Demmitt, 1993).

In our results, families always value the professional's interaction style (dimension III) higher than the professionals themselves. This result is in line with studies such as those of Bailey and Bruder (2005), McWilliam et al., (1995), who comment that scores given by families on satisfaction are usually always high, expressing in this way a great satisfaction with the role of professionals and the support they receive from them. According to McWilliam et al., (1995), parents usually feel indebted to professionals and are reluctant to express what they think, for fear of damaging the image of the service that has ultimate responsibility for the development of their child. In the same sense, Bailey and Bruder (2005) thought that families tend to feel obligated to positively qualify performance of the professional who helps their children.

Now, if this effect exists in our data, it is only observed in that dimension III, referred to the professional interaction style. When assessing specific actions carried out in the information exchange practices (dimension I) or possible problems encountered by main caregivers to follow guidelines from professionals (dimension II), are professionals who present significantly higher mean scores than those reached by families. Professionals value all proposed actions of information exchange practices, as they perform them more intensely or more frequently than the families that are subject of them.

High scores indicated by both agents in dimensions III and IV, referred to styles of interaction of the professional and actions carried out to help the personal growth of the main caregiver, indicate that relationships between Primary Caregivers and professionals are based on respect, trust, listening, availability, etc. These aspects are undoubtedly part of positive relational professional practices (Espe-Scherwindt, 2008, García-Sánchez et al., 2014). These results are in line with what was expressed by authors such as Dunts and Dempsey (2007), McWilliam, Winton and Crais (2003), among others, who consider that these aspects undoubtedly mark relationships and are the basis for a truly coordinated work between parents and professionals.

In dimension IV, the lowest scores obtained by professionals, where those items that refer to involvement of other family members and the invitation of the family to participate in training activities or opinions exchange. Leaving aside these aspects, it makes it difficult to count with: resources from family and social supporting networks and also with the positive implications they have in EI. As Serrano stablished (2007) there are relationships between social support and different aspects of the child's development and the functioning of parents and family.

It is interesting to note the set of items that have resulted with a greater volume of blank responses. For example, the one related to flexibility for intervention in the environment, which was the one that obtained the lowest score of its dimension. (Dimension III). This item (item 30) was not answered by 35.7 % of the families surveyed or by 28.9 % of the professionals. Quite possibly this was due to understanding that they should not value a practice that was not done. On the whole, this item is the one that more agents surveyed have left without answering.

The following less-answered items are those referred to giving materials to families or documents for personal growth (not answered by 15.9 % of the families surveyed); taking into account the needs of the family to propose interventions (item 42), not answered by 12.9 % of the professionals surveyed; and to discuss objectives of intervention with family (item 36), in this case, not answered by less than 57.7 % of professionals. All this are participatory practices. Precisely the type of practices that contribute most to focus service on family and away from the positioning of expert professional models (Espe-Scherwindt, 2008).

Many of our results have led us to interpretations that find support in results described by Sawyer and Campbell (2009), who show that perception of professionals about their own practices does not seem to coincide with the reality of the EI services. They also coincide with the study conducted by Cañadas (2013), who concludes that family participation is not a usual practice, at least in the centres of the Valencian community. On the other hand, these results are totally opposite to those obtained, with Portuguese samples,

by Pinto (2013) or those exposed by Boavida, Aguiar and McWilliam (2014). They show that the use of contextually mediated practices and training for use of individualized family support plans based on routines are widely used in Portuguese contexts. Portugal is a country where by law, the EI is developed following family-centred practices (Pinto et al., 2012, Serrano & Boavida, 2011).

Conclusions

Results obtained show us a clear tendency, on the part of professionals, to use relational rather than participatory practices. Thus, there is a need to promote a change to bring us closer to the international standards of practices centred on the family, which are currently the most recommended.

The interpretation of many of the answers offered by professionals, compared with the interpretation of answers provided by families, show us two different perceptions. The professionals are convinced that they are really trying to involve the family in the intervention and the family doesn't not know how or can't put into practice the recommendations made to them. On the other hand, the responses of the families make us see that the concrete actions of these professionals are still far from the usual participatory practices in family-centred services.

Incorporating training programs for professionals could substantially contribute to improving the quality of the intervention and bring it closer to family-centered models. These training programs should include the use of tools such as interview based on routines, in order to use it to establish functional intervention goals and objectives in the child's natural environment as proposed by Boavida et al. (2014). Likewise, they should include other possible strategies, such as the use of contextually mediated practices, as described by Dunst et al. (2012). They could be very valid alternatives, to try to develop more positive and successful interventions, thus achieving greater adherence of the main caregivers to this type of intervention.

Although official documents, such as the White Book of the TA (GAT, 2000), recognize the need to involve the family in the intervention and make them competent and responsible of favouring the development of their child, surely the practices that are being developed by the professionals are not contributing in the best possible way to this. In this sense, our results should lead us, perhaps, to become aware of the need for a conceptual change, which in other countries of our environment already is being carried out for years.

This process of joint reflection will help us to establish improvement proposals aimed at building parent-professional relationships that are more effective, sincere, open and flexible; where everyone can become considered part of the team thatseeks a common goal: the physical and emotional well-being of the children and their environment.

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