

# EARLY CHILDHOOD INTERVENTION ACROSS EUROPE

Towards Standards, Shared Resources And National Challenges

Edited by  
Manfred Pretis



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# Respecting Diversity and Introducing Standards

Manfred Pretis\*

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## 1. Introduction

The current book represents a critical discussion of recent developments in early childhood intervention in different countries across Europe and relates to the question of future standards in this field. Although the contributors might not represent all EU27 countries, a range of chapters included relate to other European initiatives (Report of the European Agency, 2005; Carpenter et al., 2009) and provide insight into different national approaches towards vulnerable children and their support needs. As the term 'vulnerable' indicates, this book also wants to contribute towards issues of future developments in the system of early childhood intervention, with the intention to extend early childhood intervention services to all children in need. Current demographic data indicates that up to 20% of children and adolescents need some kind of support (Maybery et al., 2005), although this does not mean that all these children need early childhood intervention. Taking into account these numbers, it has to be clear that the current system in early childhood intervention in Europe covers around 4 to 6 percent of children per birth year. It is evident that the systems are only able to cover some aspects of the needs of families and children. Alongside this discussion about the target group of vulnerable children and how different countries address this issue, there is the question of evolving quality standards within the European Union.

## 2. Are we able to define standards in early childhood intervention in Europe?

Put at its simplest, a standard is an agreed, repeatable way of doing something. It is a published document that contains a technical specification or other

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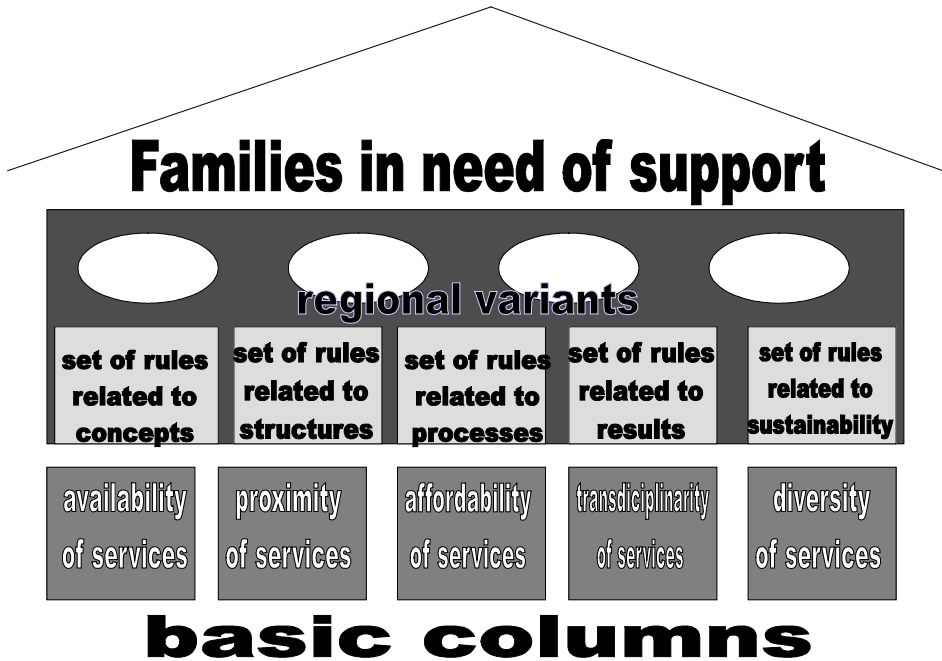
precise criteria designed to be used consistently as a rule, guideline, or definition. Standards help to make life simpler and to increase the reliability and the effectiveness of many goods and services we use. Standards are created by bringing together the experience and expertise of all interested parties such as the producers, sellers, buyers, users and regulators of a particular material, product, process or service (<http://www.bsigroup.com/en/Standards-and-Publications/About-standards/What-is-a-standard/>).

Taking into account the aspect of normative definition and the comparability and diversity of systems in Europe, it is evident that overall normative standards in terms of requirements and norms in the field of early childhood intervention will not be possible and also do not represent the diversity of systems within EU27. Attempts to address the issue of comparability and definition of minimal standards can be observed within the reports of the European Agency for European and national policy makers. (2005/2010). However, these general recommendations can only be regarded as the cornerstones of a framework on the socio-political level with very open implications for different national systems. Regarding these cornerstones, the European Agency (2005) defines five requirements related to early childhood intervention systems:

- A. Availability of services for all children in need
- B. Proximity of services
- C. Affordability of services for all parents and children in need
- D. Transdisciplinarity of services
- E. Diversity of services

These five requirements can be seen as basic columns on which the system of early childhood intervention within national, legal and structural contexts can be based. However, the issue of standards within the operative level of services still remains open.

Graph 1: Families in need of support



Taking into account the diverse historical and conceptual approaches towards early childhood intervention, (as also described by the contributing authors) it could be hypothesised that standards relating to the operative performance of services and systems can only be defined as a set of rules, which the national systems are then able to fill with contents (as described by Pretis, 2009).

Comparable to the five political cornerstones of ECI, a critical discussion on operative standards in early childhood intervention needs to focus on five different levels:

- a. The conceptual level of the ECI system or centre: this includes the legal basis of ECI, but also the subsequent definition of concepts, key terms (e.g. prevention, family centeredness..) and indicators or operationalisations of these key concepts.
- b. The structural level: Every early childhood system and subsequently every centre needs a set of rules related to structural requirements: e.g. in terms of accessible infrastructure necessary for parents and children, the contractual basis of service delivery, professional training requirements, equipment, general organisation and e.g. leadership or decision making processes.

- c. The level of processes: Within the system of early childhood intervention this relates to all formative issues which are performed together with the children, the parents or also within transdisciplinary teams (first contact, anamnesis, diagnosis, exchange about working hypothesis, joint decision making, intervention, evaluation, transition). To enable maximum transparency, these processes should be described publicly, through e.g. quality handbooks which can be read and understood by parents and staff or stakeholders. It should be evident that the processes carried out should correlate highly with the key terms and indicators of the concept and existing structures.
- d. The Outcome level: Most outcome parameters in Early Childhood Intervention refer to prevention (and its indicators). If e.g. family centeredness is one key term in a centre the outcome should be measured in relation to this key term. Even though as professionals and researchers we are aware that this correlation between key term indicators and outcome parameters is a challenging issue (as operationalisations of the key terms might not always be possible or easy) this main linkage between the different fields and sets of rules has to be highlighted. It is observable that many systems and centres- although using socially accepted key terms – do demonstrate difficulties in correlating their key terms with outcome parameters.
- e. The fifth set of rules refers to the issue of sustainable impact. We are aware that most early childhood intervention centres do not have the means to measure the sustainable impact of their intervention. Usually, after having attended a range of programmes in early childhood intervention, children and parents will leave for transition processes e.g go to kindergarten or school. However, it should at least be part of the internal reflection process to think about the broader impact of the service in early childhood intervention. We are aware that impact evaluation is a tricky issue, as for example, the European Agency working group in early childhood intervention also showed some difficulty in defining and analysing this important aspect.

### **3. Who should define this set of rules?**

It is pointed out by Pretis (2006) that defining quality in early childhood intervention occurs mainly through a dialogue between the key players in the field:

### **a. Parents**

In most cases parents have to be active in order to come into contact with early childhood intervention, as they are usually the main supportive part within education and rearing. This means mean that parents should be involved in all decision processes of an early childhood intervention centre,

- starting with a critical discussion of the concept,
- an implementation of a parent committee within the decision making structure of the centre, and continued by understandable working contracts between parents and professionals in within a partnership
- being involved in all processes relating to the early childhood intervention with the child or with themselves and
- being able to make choices relating to e.g. decision making processes or transition processes.

Although these requirements are well understood by most professionals in Europe, there is still a long way to implementing this dialogic structure (see also the contribution of Sohns, Hartung and Kraus de Camargo in this book).

### **b. Children**

This is the most difficult part of the dialogue as children within the system of early childhood intervention are

- the primary target group (the child has to qualify for this service, not the parents!)
- However, we can observe that, besides from evaluating the programs in terms of impact etc., there is little research into how children feel about early childhood intervention: whether they like it (observable by which parameters), and whether there are negative side effects, as mostly parents decide whether their children take part in the programs.

Future approaches of self-advocacy e.g. comparable to the “People’s first” (<http://www.europepeoplefirst.org/>) movement could play a stronger role in relation to this issue. Also, analysis of the memories of children who obtained early childhood intervention could be a source of information and include children more in terms of full participation. A stronger emphasis has to be put on the aspect that as professionals we do something “with children”, based on partnership models with parents but we do not really know how children feel within this triangle between professionals, parents and themselves.



### **c. Financial bodies**

Assessing standards and quality whilst excluding the financial bodies represents a one-way road. The sets of rules related to concepts, structures, processes and expected outcomes have to include a financial perspective and therefore usually also terms such as efficiency and effectiveness. Here we can also see a triangle: Services (ECI centres) are usually financed by administrative, governmental or state structures, however, these structures do not generally have sufficient information on early childhood and how to understand multi-disciplinary work. Each institution usually only sees “its part”: health focuses on (medical) treatment, social on (family) support and education on the “child” – generally in institutional settings like nurseries or kindergarten. Contributions e.g. by Detraux, Gutiez, Robertson and Messenger and Sohns, Hartung and Kraus de Camargo highlight the diversity of pathways and the need towards coordination of services. For parents this multiple entrance point creates confusion, and it is no wonder that in his contribution, Diken points out that it is more by chance that parents obtain the right service. Therefore, one major motivation for service providers has to be to increase understanding and transparency of ECI and to highlight preventive effects and the impact of the service.

### **d. Institutions and representatives of professional associations**

As pointed out before (see also graph 1), each set of rules is highly connected with national, and sometimes regional idiosyncrasies. Sometimes the impression is given that the systems exist in parallel universes: here we have ECI structures in the field of health, there we find organisations in the social field and (to mention as an example) overlapping structures in education. We also see that most centres work locally (in terms of “proximity”). As resources for cooperation, exchange and transdisciplinary work are restricted, every centre tends to create its small “world”: cooperation and communication is mostly based on personal contacts and sympathy, but not on structured coordinated networks. This lack of coordination can be seen as one recurrent theme within most of the contributions. A best practice example can be found in some provinces (Bundesländer) in Germany in terms of supra-regional “Arbeitsstellen Frühförderung” (in terms of exchange, lobbying institution, coordination) Therefore it is necessary that the representatives of professionals’ associations like VIFF Vereinigung für Interdisziplinäre Frühförderung, (<http://www.fruehfoerderung-viff.de/ueberdieviff/bundesvereinigung/>) in Germany (or in Spain the “Grupo de Atención temprana” with its “White Paper on Early Intervention”) (Real Patronato, 2005 in Spain) should be included in this dialogue process.

### **e. Research**

Initiating a dialogue about sets of rules, developing concepts, defining processes or evaluating the impact of ECI can be seen as a continuous reflective process, which also needs an “outsider” view through research including evidence based data. However, based on the diversity of systems in early childhood intervention in EU27, this research input is not always available.

Even though “increased research interest can be found in relation to the “early years”, it can also be observed that the majority of research (and funds) has gone to the field of typically developed children: towards early language stimulation, early (academic) learning processes e.g. how to read, write... Even though political decision makers and institutions increased their sensitivity towards the needs of the children (in terms of general educational frameworks e.g. in Austria (<http://www.bmukk.gv.at/medienpool/18698/bildungsrahmenplan.pdf>), quality indicators, child/carer ratio); this general global discussion related to issues of early education has not yet reached the field of early childhood intervention for vulnerable children. Kühl (personal communication 2010) rightly points out, that a conceptual discussion about the way we understand early childhood intervention in Europe in terms of a transdisciplinary approach has not happened. This lack of discussion can also be seen as a major hindering factor towards an in depth analysis of the impact of ECI. There is the general impression that (fortunately) political decision makers – within the last 30 years - agreed to implement ECI systems in most European countries. However – compared e.g. to the situation in US – asides from some local initiatives by researchers, nobody seemed to be interested in ongoing research related to ECI. Only now, recent developments in the field of professional training (specific bachelor degrees in Gera ([www.gesundheitshochschule.de](http://www.gesundheitshochschule.de)) East Germany) and Hamburg ([www.medicalschool-hamburg.de](http://www.medicalschool-hamburg.de)) and future Masters courses (see last chapter) might stimulate some new initiatives towards evidence based research in ECI.

## **4. What can the following book contribute to the discussion?**

The contributions of the partnership focus on national and regional contents and reflect the ongoing discourse on different levels. All authors describe a sometimes dizzying diversity of services and agencies responsible. How must parents feel when faced with these multiple pathways towards adequate support

for them and their children? In all countries however, the legal basis, concepts and structures can be identified. Despite the high consensus on conceptual key terms (prevention, transdisciplinarity, family-centeredness, resource-orientation..) significant differences “how to do the things in practice” might be observable. Because of this, Guralnick (2005) warns that due to the complexity of the challenges, the task of working in ECI can easily overwhelm even the most dedicated professionals.

This complexity of challenges can be found e.g. in relation to the issues of existent child focus and cooperation with the family or network needs (see the contribution by Detraux and Thirion or Giné, Bacells and Mas) or the challenging situation in Germany with its historic polarity between medical and pedagogical services and how to overcome it within the concept of “complex aid” (see the contribution of Sohns, Hartung and Kraus de Camargo). However, terminological discussions are still present, as Diken but also Sohns, Hartung and Kraus de Camargo point out in their contribution: do we talk about early “aid” or “support” (highlighting more the social or pedagogical aspect or early childhood “intervention” (still with a strong medical connotation, even though systems tend to move towards more “social” and “participative models” (see the contribution of Alisauskiene).

An overall consensus can be observed in relation to the primary vulnerable target group. Most of the authors talk about eligible groups in ECI as being around 4-6% of children age 0-6.

Within this diversity of needs, agencies, methods etc. the concepts of a “lead professional” or key person (e.g. within a jigsaw of services described by Robertson and Messenger for UK) can be assessed as one future way to deal with complexity. The basis of a specific professional training as described in the last chapter by Pretis within the Precious Project could represent one way to create a common base within the “teams around the child”.

The authentic reports about families in need and the letter from a mother within the contribution of Giné, Bacells and Mas must not be forgotten. Alongside all the scientific discussion, this letter should remind us that the primary issues are not about roles in transdisciplinary teams, power games between diverse professional groups or ministry targets, but rather, vulnerable children and their families are at the centre of interest.

Thank you to all partners of the Precious project for enabling this learning and cooperation during our 2 years European partnership. Also a special thank you to Katharina Oberhofer, who with her patience and enthusiasm contributed to this publication.

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# Early Childhood Intervention in Austria

Manfred Pretis\*

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## 1. Families in need for support

*Maria K (age 36, married, 2 typically developed kids aged 3 and 5) who lived in a rural village in Upper Styria, gave birth to her third child. Pregnancy and delivery was without complication. The obligatory screening test for hearing impairment performed at the clinic did not show any problems. The future mother proceeded through all necessary prenatal screening procedures, which are provided for all pregnant mothers in Austria within the free of charge mother-child-examinations (Mutter-Kind-Pass-Untersuchung). In this rural area the examinations were performed by the family doctor (GP), as specialised paediatricians were not easily available.*

*After giving birth and following the mother-child-examinations (which are the pre-requisite for some financial allowances) the family also did not experience any concerns. However, Max showed some personality features which were unknown to the family. He seemed to be too interested in social contacts and sometimes it was difficult to comfort him. However, based on their experience as parents and the assessment of the GP (family doctor, who could also perform the above mentioned "mother-child-examinations") they did not worry and followed a strategy of "wait and see".*

*When at the age of 1,5 Max showed almost no signs of expressive language, the parents started to wonder what was going on. First they consulted the internet, finding a lot of unclear possible reasons. They made an appointment with a specialised paediatrician in the next district city, who suggested they observe the situation.*

*As the communication behaviour of their son did not change and as he developed a specific – in the eyes of the parents – "strange" playing behaviour (watching*

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*the movement of curtains), the parents started to worry more and consulted the paediatrician again, who mentioned – for the first time – the possibility of an autistic spectrum disorder. The parents – shocked – afterwards tried to contact other specialists and consulted the internet, which made them even more confused.*

*However, the diagnosing paediatrician, recommended that the parents ask for early childhood intervention, although, he was not exactly sure how to do this. After trying to reach the responsible social worker, they were informed that they had to apply for this service through the local administration and that their child had to go through a process of expertise. The parents were a little bit worried about all this new information, as their child would have to be labelled as “disabled” or “at risk to be disabled”. The parents applied for the service, underwent an expertise process with an independent team, which assessed the individual need of support for the family. Surprisingly, the assessing independent team (clinical psychologist, social worker) worked in a very child and family centred way and the family felt quite welcomed. After 6 weeks the local administration decided that Max – based on his diagnosed symptoms – is at risk to be disabled and facilitated 42 units of early childhood intervention (including cost coverage).*

*The parents were asked to contact the local (NGO-based) early intervention centre and a first home-based contact with a professional was organised. Together with the parents – based on this first contact – a draft intervention plan was designed for the local administration. However, a specific individual family support plan (in terms of a working contract with the parents) was developed within the first 2 months of intervention. The professional, based on her specific obligatory training (90 ECTS post-secondary, non-tertiary training), performed home visits every week (1.5hr) and created a support network including contacts to another ASD-specialised institution.*

*Within the next 1.5 years of intervention the probability of the ASD diagnosis increased, however Max made good progress and the parents were slowly able to see the specific developmental needs of their third child. However, as they followed information on the internet, there was a continuous discussion with the parents whether Max would need additional behavioural-oriented therapy. The ECI professional and the parents in this context did not always reach a consensus as ECI in Austria defines itself to a large extent as a general pedagogical support in terms of parenting and not specifically as therapy. Also, the two siblings were included in ECI (in terms of play activities and reading books about what was going on with their brother). However, the grandparents showed a lot of problems in accepting a possible diagnosis. Before entering the kindergarten at age 3.5 (Max was born in*

*April), the ECI centre included Max in a playgroup of 3 children with special needs, even though because of his sister and brother he was used to social contact.*

*At age 3.5 Max was able to attend a mainstream kindergarten in the community (that the parents were entitled to). They applied to the local administration for specific (free of charge) mobile teams within the kindergarten system (consisting of special educators, psychologists, speech therapists and physiotherapists) who joined the kindergarten of Max once a week. The ECI professional followed the transition period for 3 months and then finished her service by sending a final evaluation report to the local administration.*

## **2. The system**

Early childhood intervention in Austria is a scientifically based pedagogical preventive service for children with disabilities, children at risk or children from socially disadvantaged backgrounds and families (Pretis, 2009). It is largely provided in the natural context of the child. Alongside counselling, child centred methods are used in order to prevent further disability and increase the quality of life for the parents (target population around 3-6% per birth year, including children at social risk, Trost, 1991)

The system of ECI (for children with disabilities or at risk) is generally divided into 2 sub-sectors

- a. general ECI (for children with defined motor, cognitive or emotional disabilities)
- b. sensorial ECI
  1. for children with visual impairment and for
  2. children with hearing impairment.

Most of the systems of general ECI will be provided until the child enters kindergarten or comes to school. Sensorial ECI might be implemented in kindergarten systems. Alongside this service – based on a necessary label “disabled or at risk” - ECI is also available in relation to child welfare (provided by the same centres, but based on the Laws for Child Welfare).

Early childhood intervention is largely provided by local early childhood intervention centres (NGOs), which provide services once a week for about 1.5 hours working in the natural context of the child (at home) involving parents,



siblings and the child's other relevant attachment people, e.g. grandparents.

As mentioned above, ECI is primarily provided by educational specialists who, depending on provincial laws, have to pass a specific training to be able to work in this field. The team around the child is created by the ECI specialist him/herself. During his/her transdisciplinary work the professional contacts other relevant professionals, e.g. physiotherapists, family doctors, speech therapists etc. Alongside ECI a child in need could also obtain other medical or paramedical therapies or treatments.

In most provinces in Austria ECI is a well-defined service within administrative structures, and parents will have to apply to the local administrative structure to obtain ECI. Children will qualify for these services if:

- a. they are disabled or at risk to be disabled (mostly this is based on a medical or professional expertise) or
- b. the family system displays dysfunctional structures and the system itself shows a negative impact on the child (child welfare system).

Most of the provincial laws in Austria still focus on the aspect of disability or being at risk to be disabled. However, the target group consists more and more of children with unspecific developmental delays or children with backgrounds of social disadvantage.

It is noteworthy, that Austria has a federal structure and that all information does not necessarily apply for all provinces (e.g. in Vienna and Salzburg families do not need qualifying processes as – comparable to Catalunya - services are delivered to all children in need depending on available resources). In other provinces (e.g. Lower Austria) ECI has to be cofinanced by parents.

## **2.1 Concrete procedure for children disabled or at risk to be disabled**

- a. Parents apply to the local administration for help or support for their child. They will usually get this information from the clinic, social workers or kindergarten teachers. General practitioners still follow a strategy of wait and see.
- b. Parents will need to undergo a procedure of expertise. In some provinces the expertise of a medical doctor is necessary. In others, independent teams of social workers, medical doctors and psychologists might do the assessment.
- c. The local administration defines whether the child is “disabled” or at risk

to be disabled and defines the kind of support based on a taxative list or the frequency of support.

- d. Parents may appeal against the local government's decision
- e. Parents are given the permission to obtain the service and contact the local service provider. The local service provider, based on following units with the parents, creates an
- f. individual family support plan.

## **2.2 Concrete procedure in the system of child welfare**

- a. Generally the social worker will initiate the process of support
- b. The family will be "convinced" that the child needs this specific developmental stimulation
- c. The local social welfare department will define the kind of support and the quantity
- d. The social worker will stay in contact with the early intervention team which might be contacted by the parents or the social worker him or herself.

## **2.3. Concrete steps within the family (Pretis, 2002)**


### *Phase of first contact and warming up:*

The early childhood intervention specialist will introduce him/herself, will explain the procedure of ECI and will send an individual family support plan (see Figure 1) as soon as possible to the administration.

Figure 1: Example of a Support Plan for the local administration

Early Childhood Intervention SINN

To the Local Administration in YYYY



**Concern: Support Plan**

Name of the child: Max XXX  
Birth date: 13.4.2006  
Diagnosis: Not specified developmental disorder (DSM 315.90)

Based on the expertise of Dr. Y and our first contact with the family (17.12.2009) we kindly send you a draft individual family support plan.

**Child oriented goals:**

- Stimulation of development by age appropriate toys

**Family oriented goals:**

- Increase the sensitivity of the parents towards developmental needs;
- Perform guidance and talks with the parents regarding the possible ASD diagnosis
- Active involvement of siblings

**Transdisciplinary goals:**

- Assess the possible necessity of autism-specific therapies

**Proposed intervention:**  
Early childhood intervention once a week, mobile.

*Next steps: Creating the working base together with the parents*

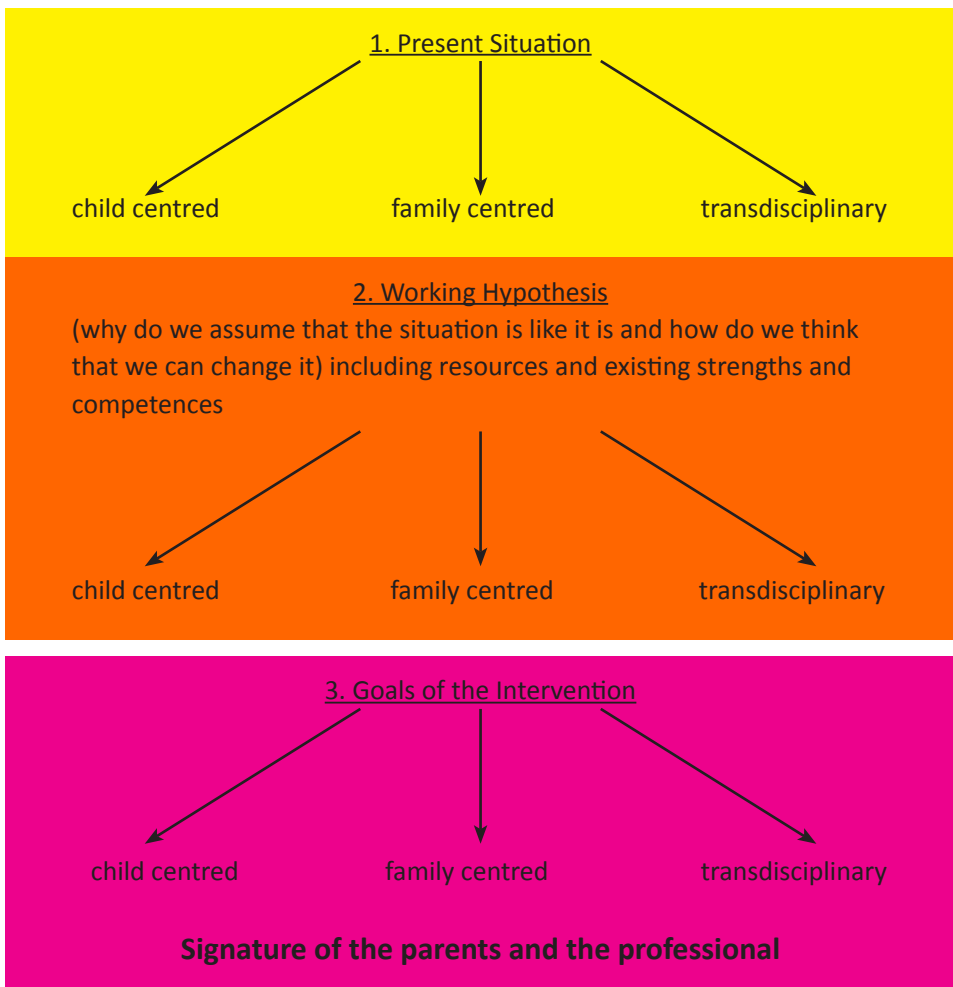
After approval of the general Support Plan by the local administration, the ECI-professional will perform a pedagogical diagnosis and/or observation phase together with the family, enabling hypothesis about the aetiology but also the concrete support. The goal of this phase is “informed consent” and a so called

“working contract” or individual family support” plan together with the family regarding the needs of the child and the family and subsequent support activities

- a. for the child in terms of developmental stimulation,
- b. for the family in terms of family support,
- c. in terms of transdisciplinary cooperation (with whom do I have to cooperate?)

Figure 2: Individual Family Support plan

### Individual Family Support Plan



Concrete Procedure during the units/visits

Home visits are usually performed weekly. The professionals follow their defined goals, mostly with child-oriented methods in terms of enabling new experiences, empowering own strengths of the child. The main work with the parents consists of strengthening parental empathy and sensitivity. Parents, mostly mothers, are actively included in the process.

Feedback is given about the involvement of the parents. The support processes with the parents depend on the phase of coping: in the very beginning grieving processes might be present, over time this changes towards increased sensitivity and usually at the end of the service questions of transfer, e.g. towards kindergarten are discussed.

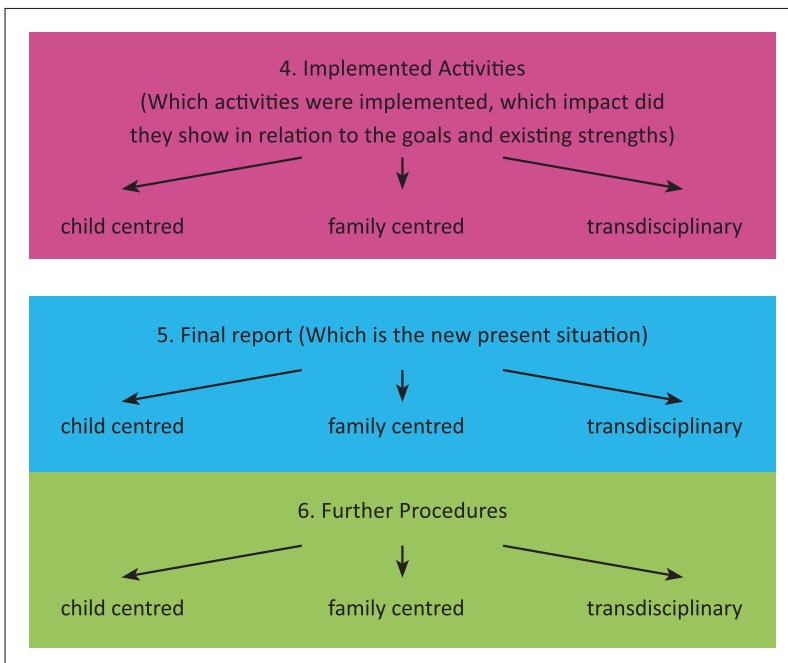
The goal oriented process is reviewed together with the parents, usually after 6 months, based on video analysis. Possible changes of the goals are discussed. At the end of one year an evaluation process has to be performed, including an official report for the local administration.

Figure 3: Schuchardt helix of coping with disability



(Schuchardt, 1994)

Figure 4: Evaluation of the Individual Family Support Plan



The age of intake into the programmes in Austria in the year 2000 was 26 months, including children with a background of social disadvantage. However, it can be hypothesised that children with established disabilities are already detected from the day of their birth and the contact with the early childhood intervention centre is made immediately (Pretis, 2002). The waiting time between application and concrete start of the intervention is about 2 months. The mean average duration of children within the programmes is about 2 years.

### ***Evaluation and Transition***

After the end of the programme children usually attend kindergarten with, in most provinces, a range of support systems. Usually a 1 till 3 months transition period between the systems (early childhood intervention and kindergarten) is implemented.

## **3. The background**

Early childhood intervention is based on (9 different) provincial laws. There is a general consensus about the key terms of early childhood intervention, however the organisational structure and actual procedure of financing can be quite heterogeneous (Pretis, 1998).

In most provinces early childhood intervention centres are located in each political district (more than 100). However, there are some differences in Austria: in Styria, the most southern province, the number of centres is quite high (about 40 different service providers). In other provinces one service provider provides all the services. Services are up to 95% home based and financed by social services. In Lower Austria some medical services also provide centre-based services (including some financial support from health sector).

Financing of the services in most provinces is „per capita“, meaning that, based on the commission of the local authority, the service provider is paid per performed unit (with exception of Vienna and Salzburg). Usually 40 units per year are accepted. In some provinces (e.g. Lower Austria) the parents have to pay a certain amount of money (between 6 and 12€ per unit). Generally it can be hypothesised that the government spends about 400 to 500€ including travel costs per child per month in terms of educational early childhood intervention (not including other medical therapies, e.g. physiotherapy, speech therapy, occupational therapy or medical care, which is covered by social insurance).

On a sociological level it can be hypothesised that ECI as an initial and very important service for parents will have an impact later on mainstream integration

and inclusion of children with special needs. Generally children coming from socially disadvantaged backgrounds show higher benefits of ECI regarding socially high risk families (Károlyy et al., 1998 described a preventive factor of 1 to 4). According to our own studies in 2000 we can hypothesise that, within the heterogeneous group of children with disability and social disadvantage, about 18% of the children did not need further therapies after ECI.

### **3.1 What are the specific qualities of ECI in Austria- in the context of criteria of the European Agency (2005)?**

ECI in most of the Austrian provinces is a unique, well-defined profession. They are paid based on a collective agreement. In some provinces ECI requires specific training in terms of university courses. This is offered in Graz and Vienna. Only after finishing these specialised courses, are professionals allowed to work in this field. ECI service is mainly a mobile service, working in the context of the family. In kindergarten systems other mobile services might be available (with some exceptions).

#### *Accessibility of the services*

Based on the law for persons with disability, parents have the right to obtain ECI. In most of the provinces this service is free of charge and easily accessible. Some differences might be seen between urban areas and rural areas, where professionals may not always be available.

#### *Affordability*

Generally ECI is affordable for the parents, although in some provinces they have to pay a small amount. In the field of ECI for children coming from disadvantaged social backgrounds this service is generally free of charge.

#### *Proximity*

As ECI centres are locally based and as the professionals are mobile and are mostly working at the home of the parents in the systems, they are near the children and families.

#### *Quality*

The issue of quality is mainly based on

1. The training of the professionals
2. Internal quality indicators and measures of the ECI centres and
3. Structural requirements by the government

Aside from the reports and structural quality indicators, it is very difficult to compare the quality of centres.

#### **4. Challenges for the ECI system in Austria**

The issue of training and comparable quality remains open, even though in some provinces the training is partly regulated in terms of 90 ECTS university courses. This does not represent a full 120 ECTS Masters as suggested in EBIFF ([www.ebiff.org](http://www.ebiff.org)) and PRECIOUS ([www.precious.at](http://www.precious.at)) and focuses to a great extent on children with a defined disability. However, 50% of the children come from a socially disadvantaged background. In this context new vulnerable target groups are still not adequately addressed: LLL project “KIDS STRENGTHS” (KIDS in the CONTEXT of MENTAL DISORDERS - Skill training to Empower Teachers, Health Professionals and Social Workers): [www.strong-kids.eu](http://www.strong-kids.eu) .

Background: the number of children in the context of mentally vulnerable parents in Europe is increasing. In the field of ECI we also see more and more parents with mental vulnerability e.g. depression, burn-out etc. Mental vulnerability has an enormous impact on the social/emotional development and attachment of the child. Therefore, new tools, methods and skills have to be implemented. The goal of [www.strong-kids.eu](http://www.strong-kids.eu) is to create training material for different professionals also in the field of ECI in order to address the needs of children in the context of mental vulnerability more efficiently (target group up to 25% of children, Maybery et al, 2005).

The second open issue addresses a “common” language in ECI, e.g. by using ICF-CY (Kraus de Camargo, 2007). However, the heterogeneity of the systems (9 different laws, 100 ECI centres with individual documentation and assessment systems) make such a hard goal to reach.

Even though no major financial cuts in the ECI system can be observed, the discussion about the effectiveness and efficiency of the system is latent. Strategies go towards deployment of tailor-made intervention systems and frequencies: however, the system of „per capita“ financing makes changes difficult as there is a high risk of financial dependency on the centre regarding the number of attended children (e.g. when children attend school or kindergarten).

Generally ECI should focus to a greater extent on evidence-based interventions and parental choice. ECI in Austria still shows a certain tendency towards socially accepted but conceptually vague terms like „holistic approach“, and family centeredness can be observed. Sometimes there is the impression that



the actual operationalisation and service provision might be quite diverse, while using the same terms (Guralnick, 2005). However, a certain comparability of services – especially from the point of view of the parents should be facilitated.

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# **Early Childhood Intervention in Belgium (French Speaking Community): Family Needs, Standards and Challenges**

**J.-J. Detraux\***

**A.-F. Thirion\*\***

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## **1. Introduction**

Belgium is generally considered as having quite a complex structure. There are three communities (Flemish, French and German speaking) that are responsible for Education. In the French Community, there are two regions: the Brussels Region and the Walloon Region. Regions are responsible for Social services (among them, the early childhood intervention services (=ECI) and also some vocational training. Each community and region has its own government (Ministers and Parliament).

Improved coordination can now be observed between regions and communities and some agreements are signed to facilitate cooperation. However, some parents are faced with different provisions from one region to another when they have to move. The following considerations refer mainly to the organization of the French Community of Belgium.

## **2. How do parents access the ECI system ?**

The majority of parents hear about the existence of ECI services through a pediatrician (for instance, in a neonatology service in hospital), a therapist, or a nurse from the Office for Birth and Child. The Office for Birth and Child (ONE) organizes pre and post-natal consultations. Further, when the parents return home after a stay in a maternity hospital, a social nurse is visiting the family, gives information to the parents if requested and presents the services the parents could need. The role of parent's associations is also important to consider when parents are searching for support. Generally, they will find the references on a website or by exchanging information with other parents. In some cases, family cohesion works as such that resources are identified by

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grandparents, siblings, etc. Furthermore, due to the development of antenatal fetal abnormality detection and diagnosis, ECI services could intervene before birth and support the parents in making decisions regarding the follow up of the pregnancy. Ethical aspects are of course a major issue in those cases.

Some parent's associations have trained parent volunteers to become "support-parents" who can visit the mother when she is still staying in the maternity hospital. Those support-parents have experienced the birth of a disabled child themselves. They intervene after the "official" announcement has been made by the pediatrician and share the parent's sorrow. Information regarding possible resources such as ECI services and parents associations are also given.

Parents report that they do not know exactly what the ECI service can offer and how it can be a support for their child. When they have first contact with the service, they generally receive relevant information through flyers and/or booklets. A recent survey (Flies, 2010) shows that parents that have no clear guidance on what they have to do, consider ECI service as mainly concerned with the disabled child and not focusing on the family as a whole. When asked, parents report that the ECI service will enlarge the possibilities for intervention and give useful information on the disability. The service will act as a referent and gather all the information from various professionals. It also represents the opportunity to share their experiences and questions. Parents are looking for very practical answers relating to daily life with their child. They also expect to learn how to react when facing the family circle and neighbors. ECI service is perceived as a mediator when the parents have to communicate with them. Of course, ECI service is also an important resource when parents are demoralized and need emotional support.

Time is an important issue to be considered. The fact of giving information to parents does not mean that they will use it immediately. The individual development of each parent and the necessity for time to "digest" information could lead to postponing the first effective contacts with the ECI service. In all cases, a clear request from the parents is needed for the ECI service to intervene. Very often the request relates to support in daily life and not therapy or reeducation. Parents want to know "what to do", and they need information about the development of the disabled child. Professionals will also suggest considering the situation of the siblings, and provide information on available resources, persons or services.

### **3. How does the system of ECI address the needs of families with vulnerable children ?**

We have asked parents to outline how they perceive the intervention of an ECI service. The following are examples of answers:

*“I take a hand (parents) that holds another hand (the service). It is a relationship. A link. The service will lead parents in a good direction.”*

*“The service is like the wind. The announcement of the disability is like big dark clouds. Thanks to the wind that blows on the dark clouds, we can see some sunny spell: The future). That’s a bit of a boost. Nobody is prepared to face disability and there are a lot of questions about the future. Now we are able to talk about the future. The question does not frighten us any longer [...]”*

*“Early intervention is like a support for education. It’s like a motor, a small motor that parents sometimes want to stop. It’s also a motor to push the child and show us how he/she will be in the coming future [...]”*

*“For us, ECI is like a present [...]”*

ECI services have to be solicited explicitly by parents or representatives of the parents to intervene. A diagnosis has to be made in order to be eligible for ECI support. A medical report must be registered by the authorities in order to benefit from the ECI. As we can imagine, in some cases this requirement can represent a problem in the case of at-risk children. The label “developmental delay” or “suspicion of intellectual disability” is therefore used. Once approved by the authorities, there is no further re-evaluation except if the diagnosis is not precise enough.

The ECI service supports both the child and the family. The support consists of an active participation in following up the child and his/her family’s individual plan. Professionals have to respect the socio-cultural habits and beliefs of the parents. They have to promote the use of regular services as far as possible. Four main missions are devoted to those services:

- individual support for the education of children with intellectual, neuro-motor or sensorial disabilities within the regular environment.
- educational and social support for parents in order to empower them in coping with the daily difficulties related to the disability and ensure the best development for the child.

- promotion of prevention and recognition of disabilities before, during and after the pregnancy and joined up working with any related initiatives.
- development of collective action and a community-based approach, aiming to provide information and training for professionals and the general population.

The ECI service can achieve cumulative work with other services such as family placement services or centers for functional rehabilitation. The ECI team generally includes a psychologist, a social worker, a physiotherapist, a speech therapist, an occupational therapist and an educator. There is also a referent physician (usually a pediatrician).

It is important to note that the services cannot directly provide medical care or therapy. This specific activity is the responsibility of practitioners in hospitals or in rehabilitation centers or private therapists. As a consequence, ECI services have to work in terms of networks and very often play the role of mediator.

The ECI services operates from birth to the age of 8 yrs. As already mentioned, the service also has to promote prevention before birth during pregnancy and can support parents when a fetal abnormality is discovered. The ways in which it works are as follows:

A bilateral contract is established with the parents and includes: the identity of the contracting parties; general objectives to be reached by the support of ECI; the establishment of an individualized support plan; date of the beginning and the end of the contract; information about the family's involvement in an evaluation process of the support provided by the service; the amount of the parent's contribution; the person or legal entity responsible for payment; ways of cancellation and address of the administration where to send a complaint.

An individual plan for the support is established within the first three months and has to mention at least the following items: information about the situation of the child and family; specifics regarding how to achieve the support tasks related to the expectations and identified needs of the family and child; the services that will be solicited; the nature and number of actual services to be delivered and finally the way of evaluating and updating the support process. This document is signed by the legal representative and is joined to the child's file.

Parents have the choice to accept or not to accept interventions at home. Most parents accept that professionals intervene at home even if they are able to

come to the center themselves. Parents consider at-home intervention to allow them a better organization of daily life where they can stay busy with domestic tasks while benefiting from professional support. Parents can also care for their other children themselves without having to call for a babysitter (Flies, 2010). In any case, when professionals make an intervention at home, the presence of at least one parent is required!

Generally parents will regularly receive written reports on those visits as well as on the achieved assessment sessions each semester. Parents are always asked if the reports can eventually be sent to other networking professionals.

Interventions takes place once every fifteen days, or even once a week at the beginning. After this, the rhythm of the visits can decrease to once a month. Professionals of two or three different disciplines can alternate for those visits.

Assessment is always achieved using a multidisciplinary approach and the support given to the family is transdisciplinary. When visiting the family, any professional whatever his/her own discipline is, has to have a look at various aspects of the child's development as well as at the environmental factors that influence the development.

A financial contribution from the parents is asked for. The amount is about 80 Euros a year and calculated according to the number of effective interventions. It never exceeds 25 Euros a month (index-linked). Some additional contribution for specific activities can be asked for but parents have to agree explicitly to this.

#### **4. Background to the system**

The first ECI services were created in the early eighties and the first provision appeared in 1990. The more recent Act has been promulgated in 2004 by the Walloon Region. It has been created in collaboration with professionals and also concerns services for adults. In the Brussels Region, there are 5 services (for 1 million inhabitants) supporting young disabled children and their families. In the Walloon Region, there are 18 ECI services (for 3.5 millions inhabitants). The organization of the services differs from one Region to the other (AWIPH; Arrêté du Gouvernement wallon; Portail de la Communauté française). In Brussels, some services are also dealing with children at school age and with adults. In the Walloon Region, the services for young children (0-8 yrs) are separated from the services for children at school age (6-18 yrs) and from the services for adults (up to 18 yrs). Each service is created and managed by

a non profit organization that gets a subsidy from the government. The service can find (and generally has to!) additional funds from other sources (private, charity,...).

Legislation allows one ECI service within an area covering at least 8000 children under 8yrs. In reality, most services are dealing with a number of cases which is higher than the officially approved number by authorities. During the last decade no new services were created.

The service can be approved as multi-purpose or specialized. The multi-purpose services support children whatever the child's disability. The specialized services support children with one specific disability (for instance: Autism, Down Syndrome, Cerebral Palsy) and also provide information and training for every service that needs it. Those specialized services contribute to research programs in the field of ECI. The service is approved by authorities for a period of 3 months to 3 years (and has to be renewed after that) and for a fixed amount of hours to support children and families.

The service has to create a plan describing the history of the service, the aims and objectives, the characteristics of the target population (disabilities, age,..), the geographical area covered by interventions, the amount of parental financial contribution, the practical organization of the service (how the work is organized, type and number of meetings, schedules, opening hours,..), the strategies used to communicate with the target population, the methodology used to assess the needs, the methods of interventions in various domains, how the service evaluates the quality of interventions regarding wider aims and regarding individual intervention plans , human resources and how training opportunities are provided.

Furthermore, every two years the service has to establish a plan for training related to the objectives, the global environment in which the service is implemented and the dynamics of the service's wider plan as well as to the current competencies of each staff member. Daily activities of the workers are written down in a diary.

The service gets an annual subsidy from the government for salaries (including a bonus for length of service) and functioning costs. It covers the equivalent of at least 2.5 full time staff (EFT). The specialized services for children with visual or hearing impairment get 0.5 EFT more. The service has to establish a team with at least one part time psychologist, social worker, therapist, educator. The enrolment of administrative workers is limited. This subsidy is



a basis to determine the theoretical amount of time units for support and the minimal number of individual files the center has to manage to be approved by authorities. Calculation of the final subsidy a center will receive is a very technical one.

The service is regularly inspected in relation on the one hand to the pedagogical activities (respect for the conditions of the agreement, effectiveness of the service plan, effectiveness of collaboration between workers, quality of interventions, existence of updating activities and in-service training,...) and on the other hand regarding the financial management (respect of rules in using subsidies). Inspectors can also act as advisors for the team.

## **5. Current evaluation of the system**

As a matter of fact, the ECI services in Belgium have succeeded in approaching the child holistically in his/her family and in various life environments (nursery, school, leisure activities,...). However, this way of functioning is time consuming and the means allocated to the services are not covered entirely by subsidies. Furthermore, the number of parents applying to benefit from ECI is increasing and the question arises over to what extent the services can take proper care of all the children and families. In some cases, registration on a waiting list is suggested, although it is evident that the lack of adequate and “timely” intervention could represent a serious injury to the child’s development.

The accessibility of ECI services seems to be quite good. A lot of information is displayed through various means and channels. However, parents report quite constantly their difficulty in finding the adequate information quickly. Empirical observations reveal that there must be a correlation between the perception pediatricians have about a disabled child and his/her developmental capacities on the one hand and the involvement of those professionals in guiding parents towards ECI services on the other hand. Moreover, where the perception about the disabled child is a positive one: it is more likely that the professional will inform parents about actual possibilities for support.

As we know, the period following the announcement of a disability is a very chaotic one. Parents need time to cope with this unexpected and completely unknown situation, while professionals with a rational attitude prompt parents to engage themselves in “useful” interventions. For the parents, a balance must be found between the need for appropriate support and the need to assimilate

the elements of the situation, find some landmarks and become able to take their own decisions. The philosophy and provisions of ECI services in Belgium are clearly oriented towards a support that leaves time for the parents. The aim is not to provide therapies immediately, but to help parents to mobilize existing resources in the nearby environment. This position, excluding pre-defined programs of intervention, raises a problem: the therapeutic interventions to be found in hospitals or by freelance workers are in some cases not sufficiently applicable and of good quality. The ECI service has no real ability to directly control those interventions.

Furthermore, networking with various services is another challenge. Many questions arise: which service can be considered as the preferable one for the parents? How should information be shared between the services (very often parents take responsibility for passing on the information to the various professionals)? Is there a possibility to control the coherence of the activities around the child and the family? How can an unproductive competition between the interveners be avoided? How can the transitions between the services at successive stages of the child's development be managed? Many risks do exist, among others:

- experiencing an illusory partnership without effective sharing of knowledge and co-construction of a plan, without the possibility for parents to adopt another way or take a contradictory position
- prompting parents to consume more and more services, fostering a need to be a “good” parent who attempts to achieve the best for the child.
- using up all the energy to manage the network to the detriment of the child's and family's basic needs.

Evaluation of the quality of the service as well as professional networking also needs to improve. The work done by Eurllyaid ([www.eulyaid.net](http://www.eulyaid.net)), which suggests the use of a scale exploring parental satisfaction, represents one aspect of quality measurement. However, some tools and methodologies have to be developed in order to ensure a holistic approach to the service quality. We could imagine that a European panel of experts can help the services to achieve an evaluation as achieved by universities, secondary education, etc.

Finally, the question of training as well as the link between research/training has to be highlighted. Professionals working in the field of early intervention generally have the following qualifications:

- Masters degree (5 years after secondary education): psychologists, some speech therapists, some physiotherapists; physicians (7 years and more)
- High School degree (3 years after Secondary Education): the majority of therapists (speech therapists, physiotherapists, occupational therapists, others), nurses, social workers, educators. All those professional qualifications are not specific for the field of ECI. No specific/complementary requirements are necessary to get a job in the field of ECI. Furthermore, it has to be highlighted that in some ECI services, parents are members of the professional team.

There are a lot of opportunities for in-service training. In the Brussels Region, 1% of the total amount of salaries are given to services in order to organize in-service training (those activities are either achieved by the service with a resource expert, or organized by schools, private associations or individual experts that bring together a small group of professionals for one or more session). In the Walloon Region, a specific budget is allocated to organize “tailor-made” training. Furthermore, some services are commissioned to inform and to train professionals from other services (for instance, in the fields of Down Syndrome, Autism, Cerebral Palsy). Parent’s associations also offer some specific modules for professionals.

To improve this situation, we could implement some specific training after the initial general bachelor/masters degree. This approach is difficult due to various issues: funding difficulties, poor recruitment (the French Community is a small one and registration fees are often a real obstacle), duration of training (usually only one year). We should probably improve existing programs in initial training to reinforce the content by focusing more explicitly on development and disabilities in infancy and by promoting cooperation between teachers of different disciplines or sub-disciplines. This way is probably more appropriate for training people to become able to cope with the large variety of problems encountered in the field of ECI. A certain degree of adaptability is indeed necessary. Furthermore, this way is likely to fit better with the promotion of an inclusive education. It supposes also that we reflect more widely on the organization of initial, complementary and in-service training in order to allow progressive advancing of knowledge and to allow possibilities for change and new career directions.

Finally, improved cooperation with researchers in the field of early development and learning would be profitable for both parties. It is important to conduct

research work on questions arising from the practice and we need to regularly give feedback from the research results to the practitioners. In the future it will be a real challenge to feed both research and practice mutually with respect for the families (no over solicitation)!

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# Early Intervention in Catalonia

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## 1. Families in need for support

*Mariola woke up from her afternoon nap and started to make some movements that were completely unknown to me: her head slumped and she closed her eyes over and over again. This was repeated every time she woke up in the morning or after a nap. Although I was a first-time mother, I knew straight away that something was not right and I would have to take Mariola to the hospital. I thought we would be a few hours waiting around in A&E and after a general examination they would tell me what was the matter and we would go home with a prescription for some medicine. But some hopes! The hours turned into days, long, lonely days in a cold room watching Mariola being submitted to tests and more tests, days without any rest, which increased the worry and the anxiety of not knowing. In the end we emerged from that period of being shut up with an answer: tuberous sclerosis, one of the so-called rare genetic disease displaying specific symptoms in various parts of the body, including the brain, but with a broad spectrum of manifestations.*

*There then began a new life for which nobody had prepared or even warned me, full of uncertainties, thoughts, unknown words and the initials of different centres and organisations. The first and most important help I had was the calm, the vision of the positive side of things and the happiness my husband conveyed to me at all times, and which he still does every day that goes by. I take this opportunity to thank you for everything, for being by my side and supporting me in the most difficult situations.*

*The second help we received was from the Early Intervention Centre at which we arrived via Mariola's neuropaediatrician and a referral from our primary healthcare centre. From the first day we entered the centre, the treatment we received from the people there was extremely cordial, warm and friendly. It was*

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*decided that Mariola should start with one physiotherapy session a week to teach her first to crawl and then to walk, as her muscular tone was low. At the same time, she was seen, and continues to be seen, by a neuropaediatrician, to monitor the evolution of the disease, the knowledge acquired, the deficiencies, and also to explain to us in simple terms the essence of how the disease is caused.*

*When Mariola was one she started to crawl and at 16 months she took her first steps. Just when I was giving birth to my second child, Marcel, the physiotherapy sessions finished and the sessions with Dolors, the psychologist, began. For about a year we have accompanied Mariola to the sessions with Dolors. A special rapport has grown up between them. They are very fond of, and also show great respect for, each other. Between games she explains to us, the parents, the reason for that activity, the aim she wants to achieve and, depending on the response, how Mariola is developing. From time to time we also have a session with her, just the parents on our own, during which she tells us how Mariola is getting on and we also tell her about our concerns, our worries and the progress we are able to observe in everyday situations.*

*Now that Mariola is nearly 4 years old, we still go to the Centre once a week “to play with Dolors”, as she says; by now she goes into the session on her own and when she comes out she tells me what they have done and whether she has behaved well or average. When we leave we always say “see you on Monday, Dolors”, in the knowledge that there we have a help and a friend.*

*Noelia Pardo.*

*Mom of a child with disability*

These simple words written by a mother introduce us to the reality of early intervention in Catalonia from the time the mother discovers that something is not quite right in her daughter's development until they reach the Child Development and Early Intervention Centre. Although the experience recounted here is unique, it provides us with an intimate description of the process that people go through, furnishing a neat introduction to this article whose purpose is to describe how early intervention (ECI) in Catalonia is conceived of, organised and implemented. To this end, the article is divided into two parts. The first takes a brief look at the history of the legislation regarding EI in Catalonia, while the second focuses on how the services involved have been conceived of and organised (goals, scope, family involvement, professional training, the route followed by families, referrals, etc.).

## 2. A brief look at the history

To understand the current state of early intervention in Catalonia, reference must be made to the way Spain is divided into different regions and how different powers are devolved to them. Spain is made up of 17 regions, known as autonomous communities, each with its own government and parliament democratically elected by the citizens living there. In spite of the fact that the Spanish parliament and government retain a number of exclusive powers, each autonomous community has a certain legislative, organisational and financial capacity enabling it to implement its own policies in certain spheres and, in particular, in social services and education. More specifically, the autonomous communities are responsible for early intervention in Spain, as, beginning in 1981, the relevant powers have been gradually devolved to them by the central government (Ponte, 2004).

An important milestone in this process was the enactment of Law 13/1982 of 7 April, known as the Disabled Persons Social Integration Act (published in the official gazette –BOE– on 30 April 1982). This Act introduced a set of measures that had a direct effect on subsequent legislation concerning early intervention in each autonomous community. For the first time it spoke of the importance of prevention and the need to intervene at an early age in the case of children having some difficulty or deficiency. At all events, the first specific regulations concerning the early intervention did not arrive until social services laws were passed in the different autonomous communities. A first feature of early intervention in Spain to be noted is the diversification of responsibility for it resulting from the fact that the funding model and system of organisation differ considerably from one autonomous community to another. Nevertheless, from the point of view of how such intervention is conceived of and implemented, it should be mentioned that the professionals involved put a lot of effort into reaching a framework agreement for the whole of Spain which was set out in the White Paper on Early Intervention (*Libro Blanco de la Atención Temprana*) published in 2000 (Real Patronato de Prevención y de Atención a Personas con Minusvalía, 2000). This document covered the following aspects: definition, objectives, main spheres of action, relationship with the community and co-ordination among institutions.

Although Catalonia has had full powers regarding early intervention since 1985, when the central government transferred responsibility for it to the Catalan autonomous government (*Generalitat de Catalunya*), the origin of



early intervention in Catalonia dates back to the mid-1960s when the first interdisciplinary teams were set up to deal with children with disability and their families during the first few years of the children's lives. Many of these teams were linked to parents' associations which were created to compensate for the absence of support and services for children that needed them (Rubert, 2010).

These early teams were the result of the enthusiasm of certain professionals wishing to address the needs of children with some sort of disorder in their development in the first few years of their lives. Those professionals had neither means, nor resources, nor official recognition, but they nevertheless believed wholeheartedly in the need to offer such a service to the population. As the years went by, various Early Intervention Centres gradually became more firmly established. These were mostly privately owned and located in hospitals, special education schools or on the parents' associations' premises, although they were not covered by any official legal framework.

The gradual growth of these services, coupled with increasing demand, led the autonomous government to publish the first legal instrument regulating early intervention in Catalonia. This was the Order, of 29 July 1985, which instituted the Sectorial Early Intervention Programme. The most important contributions made by this order have been summarised by Rubert (2010) as follows:

- Public recognition of the work done by the early intervention centres existing at that time, all of which had been set up by social and private initiative.
- Definition of the centres' catchment areas. The geographical area covered by each early intervention centre was delimited and its work in co-operation with the other children's services in the area was officially recognised. Following this Order, children's parents and/or guardians no longer had a choice of centre, but were allocated to one on the basis of where they lived.
- The creation of more centres, especially state-run centres, across Catalonia, in order to comply with the catchment area plan ensuring all areas were covered. The setting up of new centres led to the co-existence of publicly run and privately run centres.

In 1994 new legislation was introduced in Catalonia based on the experience built up, progress in regard to how the matter was conceived of and other laws passed in the social services field. Legislative Decree 17/1994, of 16, November had the effect of stimulating demand by families for early intervention and

broadened the scope of such intervention. There was a shift away from a view of the service as focusing mainly on disability and prevention to a more global and ecological perspective prioritising prevention and promoting optimum development in order to avoid or minimise possible disorders (Rubert, 2010). After this there was a gradual move to expand intervention beyond children with disability to cover children with other developmental problems or at social risk as well.

The following year, Decree 206/1995, of 13 June, brought early intervention under the Social Welfare Department. This Decree also represented progress in regard to the concepts and terms employed. In particular:

- It no longer used the term *disminució* (handicap) and introduced instead *transtorn* (disorder) to refer to a feature of the population at which the service was aimed.
- The age at which intervention could be provided in exceptional cases if really necessary was extended to 6 years, although 4 continued to be the upper age limit.
- Greater emphasis was placed on interdisciplinary teams of professionals which were made responsible for the whole intervention process, providing assessment, intervention, support and guidance to the parents and collaborating with the other young children's services.

This conceptual change also influenced the name given to the centres providing early intervention. It was changed from Early Intervention Services (SAP) to Child Development and Early Intervention Centres, the name by which they are still known today. Legislation concerning early intervention in Catalonia was completed by Law 18/2003, of 4 July, on family support and the regulations for implementing it, and Decree 261/2003, of 21 October, which laid down the current guidelines for this field.

### **3. Early intervention in Catalonia today**

Early intervention in Catalonia comprises a well-established public network of Early Intervention Centres with specific catchment areas charged with preventing, detecting, treating and monitoring children with disorders in their development.

Basing itself on the White Paper on Early Intervention (Real Patronato de Prevención y de Atención a Personas con Minusvalía, 2000), the Department

of Social and Citizen Action of the autonomous government of Catalonia defines early intervention as “all the interdisciplinary actions in the sphere of prevention, detection, diagnosis and therapeutic intervention ranging, in a broad sense, from the moment of conception until the child is six years old, encompassing, therefore, the prenatal period, the perinatal period and the postnatal period of early childhood” (Generalitat de Catalunya, 2010). This same document specifies that “early intervention is aimed at children who display (chronic or temporary) disorders in their development, have a history pointing to biological, psychological and social risk, are in a situation where they are at risk of suffering such disorders or display difficulties in rearing. Moreover, early intervention is also aimed at the families of these children”.

It should be pointed out that this conception of early intervention is in keeping with the most up-to-date views emerging from research and espoused by international bodies. We refer here to a broad conception of early intervention, the importance of the family, focus on the child’s potential, emphasis on a bio-psycho-social model, etc. (Dunst, 2000; Giné et al., 2006; Guralnick, 2001; Soriano, 1999).

As already mentioned, the Early Intervention Centres are responsible for early intervention preventive and support work. In particular, the functions allocated to them include carrying out a global assessment of the problems of the child and its family (diagnosis); providing the family with information, guidance, support and advice; giving the child with disability personalised therapeutic care; offering special schools with guidance and support; monitoring the child’s development; collaborating in prevention and detection programmes; and engaging in research, teaching and training.

The aims pursued by the Early Intervention Centres in accordance with their commitments are (Generalitat de Catalunya, 2010):

- Caring for children from conception to six years old
- Taking part in the co-ordination of the (detection and prevention) actions carried out in this age-group
- Participating in interdepartmental co-ordination and co-operation projects
- Providing interdisciplinary teams with special expertise in child development
- Guaranteeing individualised work and continuity of care.

The Generalitat de Catalunya (2010) has stipulated that the early intervention centres are aimed at:

- Children who in normal circumstances would not require such care or assistance, but whose family or social situation may make it necessary.
- Children who in normal circumstances fail to reach development appropriate to their age and therefore need special care to achieve it.
- Children with evident malformations, congenital defects, cerebral lesions due to any causes or any other anomalies.

In addition to these children, the scope of intervention encompasses the families as a unit of development, the natural environment in which the child lives and society in general, as all these contexts has an impact on the child's overall development.

So the early intervention centres in Catalonia do not deal only with children suffering a manifest organic, permanent disability, such as Down's Syndrome or Autism Spectrum Disorder, but are aimed in general at children with disorders in their development or at risk of such disorders due to their biological, psychological or social situation. From this perspective, development is understood as the result of the child's interaction with its environment, including the people in it.

Some professionals working in this area in Catalonia (UCCAP, 2004) have estimated that, bearing in mind the extent of the population at which early intervention is aimed (children with disabilities, slight and temporary difficulties, at social risk, etc.), the proportion covered should be at least 7.5% of the infant population (0-6), as against the 4.7% actually dealt with in 2008. It should be pointed out, however, that the number of children dealt with has increased every year, going up from 11,454 users in 2002 to 24,883 in 2008, a rise of 117.24% (Generalitat de Catalunya, 2010).

Although the aim of the legislation and the desire of the professionals are clearly to involve families more, the fact of the matter is that this goal is still a long way off. Indeed, following research assessing the quality of early intervention services in Catalonia with the collaboration of 36 professionals and 38 families, Vilaseca et al. (2004) concluded that early intervention is still heavily focused on the children and little on their families, since the predominant model over the past few decades has been the clinical model centred on the child's rehabilitation, leaving the family in second place. Nevertheless, the situation is paradoxical: whereas, on the one hand, it seems that the importance of working with families as the context for development is acknowledged, the criteria

the administration actually employs to determine the amount of money to be allocated to each of the services are based on the number of children dealt with, which has a negative effect on the efforts the services have to make to deal with the families.

Coming back to the aims of the Early Intervention Centres, one of the requirements is that the team of professionals should be interdisciplinary, covering all the areas of the child's development and the different objects of intervention (child, family and environment). These professionals must be specifically educated and trained in physiotherapy, speech therapy, medicine, psychology and social work (UCCAP, 2004). These are the minimum areas of expertise the Early Intervention Centres have to cover, although the larger teams often include specialists in pedagogy, educational psychology and psychomotricity.

The only requirements professionals must currently fulfil to be able to work in an Early Intervention Centres are a qualification in one of the disciplines just listed. Nevertheless, the White Paper on Early Intervention (Real Patronato de Prevención y de Atención a Personas con Minusvalía, 2000) comes out clearly in favour of requiring professionals working in early intervention to possess, in addition to their basic qualification, specific education and training in early intervention to be obtained via a master's degree. In short, the White Paper calls for specialist university courses and in-service training to ensure that the professionals working in this field are sufficiently well trained (Real Patronato de Prevención y de Atención a Personas con Minusvalía, 2000).

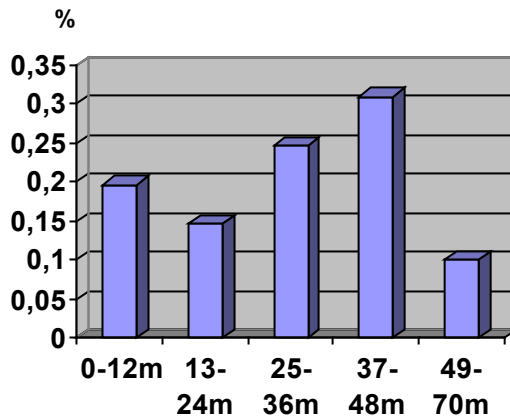
There are currently 86 centres in Catalonia (Generalitat de Catalunya, 2010) each catering for a particular sector of the population and geographic area. The advantage of this sectorisation is that professionals have extensive knowledge of the resources available in their area of intervention and of the existing services (schools, community resources, private practices, leisure and free time resources, etc.)

Some of these centres are publicly owned, while others are privately owned, but they all receive public funding and so the families do not have to pay for the services.

Children and their families reach the Early Intervention Centres in Catalonia in a large variety of ways. This diversification is probably due to the growing awareness among professionals and families regarding normal child development. This increased awareness has improved the detection of

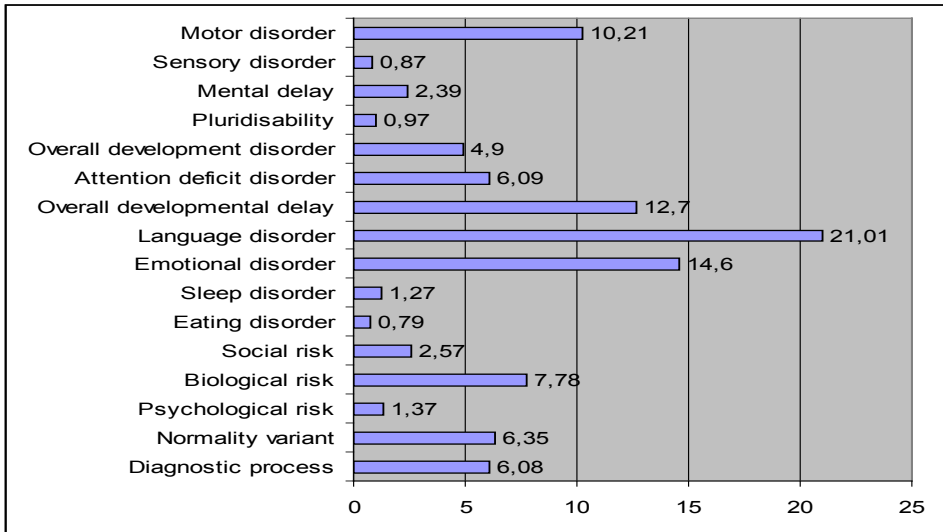
difficulties in infants at younger and younger ages, and of disorders with different aetiologies. As shown in Graph 1, in 2008 more than 19% of the children seen at the early intervention centres were less than a year old and 14.61 were under 2, although 4-year-olds constituted the largest age-group (30.99%) (Generalitat de Catalunya, 2010).

*Graph 1.* Age at which children were first seen at the early intervention centres in Catalonia in 2008 (Generalitat de Catalunya, 2010).



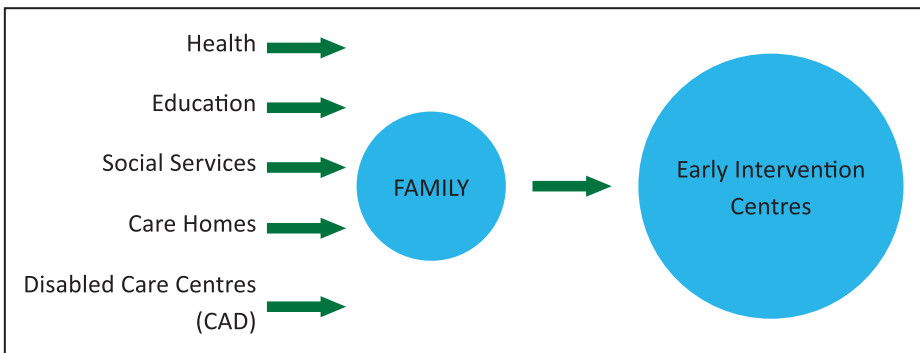
As regards aetiology, in 2008 language disorders were the most frequent reason for referral (21.01%), followed by emotional disorders (12.70%) and cognitive developmental delay (12.70%). The least frequent reasons for referral were eating disorders (0.79%), sensory disorders (0.87%) and multiple disabilities (0.97%) (Generalitat de Catalunya, 2010).

Graph 2: Main diagnosis of all the children dealt with by the early intervention centres in Catalonia in 2008 (Generalitat de Catalunya, 2010).



As already stated, not all cases reach the early intervention centres by the same route. The first symptoms are usually detected by the primary care services (health and social services), although it is often the families themselves who bring the strangeness of the development of their child to the attention of the authorities. Once the hypothesis has been confirmed, the families are informed and referred to the Early Intervention Centre. After this, it is up to the families to phone the centre for an appointment and describe their child’s difficulty. Figure 1 shows the normal route taken by families to reach the Early Intervention Centres.

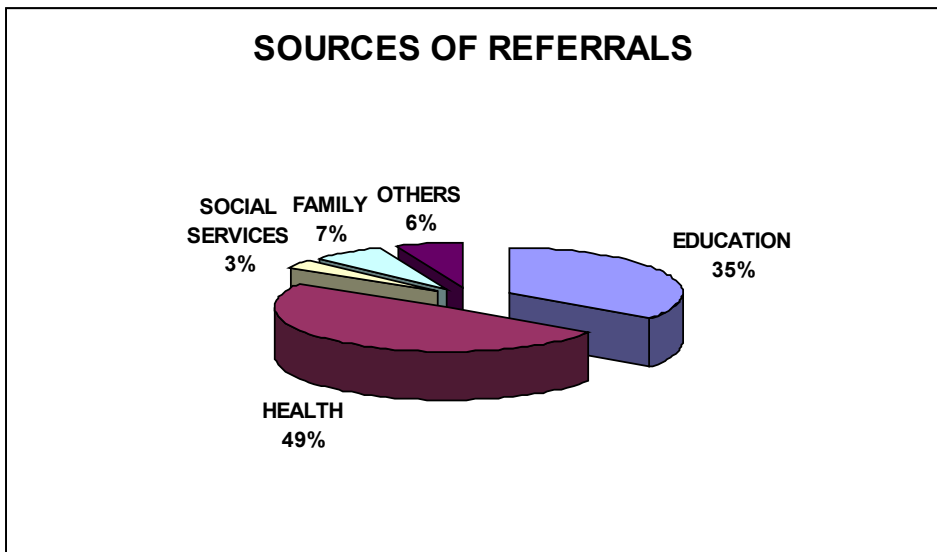
Figure1. Referral route (Generalitat de Catalunya, 2010)



As expected, the services normally involved in referring children to the early intervention centres are healthcare (hospitals, pediatric services, etc.), education (nursery schools, infants' schools, educational psychology services, etc.) and social services, as well as the legal system, care homes and disabled care centres, (Generalitat de Catalunya, 2010; Ruiz & Zaurín, 2004).

Graph 3 shows the distribution of the origins of referrals to early intervention centres in 2008: health services (49%), education (35%), social services (3%), families (7%) and others (6%) (Generalitat de Catalunya, 2010).

*Graph 3. Referral sources 2008* (Generalitat de Catalunya, 2010)



**When a family phones an Early Intervention Centre, the team takes a series of steps to assess the child and its immediate environment. These steps include:**

- a) a meeting of various professionals to decide who is to assess the child in view of the kind of difficulties reported and each professional's particular expertise.
- b) a meeting with the child's parents or guardians at which the case history is compiled: reason for the request, family history, reports by other professionals, the child's development, the environment in which the child lives and participates, and the parents' concerns and/or expectations regarding the child's development.



- c) an assessment of the child: the cognitive, motor, communicational, psychological and affective capabilities through observation of the infant and administration of the tests considered most appropriate in each case, usually the Bayley II, Batelle, Reynell, McCarthy, ITPA, Riviere, etc., scales (not specifically mentioned in the references).
- d) a meeting with the centre team to share the information gathered, make the assessment and decide on the most suitable intervention (the goals to be aimed at, the professionals to be involved, the frequency of the intervention, etc.). Normally at this meeting a functional diagnosis of the child is made taking into account the classifications in the DSM IV, ICD 10 and the diagnostic classification of the *National Center for Clinical Infant Programs* (Ruiz & Zaurín, 2004 ).
- e) Lastly, the family is informed of the assessment that has been made and the proposed intervention is explained to it.

The centres carry out a global intervention taking into account all the areas of the child's development (emotional, social, cognitive, communicative and motor).

The intervention is almost always performed with the child on its own. In some cases, while a relationship between the child and the professional is being built up or when it is thought useful for the parents to see how the professional interacts with the child, the parents are invited to be present at the intervention sessions, although in both cases their role is generally confined to that of observers.

Most of the direct intervention sessions with the child are held at the centre and usually last 45 minutes. The frequency of the sessions varies according to the degree of the child's disorder, whether the child is attending school and its emotional status.

According to Ruiz & Zaurín (2004) the different intervention modalities can be divided up as follows:

- Intensive intervention (2 or 3 sessions a week)
- Regular intervention (1 session a week)
- Follow-up intervention (every fortnight or more)

In addition to the sessions with the child, the professionals devote a large part of their work to raising the awareness of, and co-ordinating what they are doing

with, the child's tutors at school, the educational psychologists, the area social workers if necessary, etc. They also put aside time for training, teaching and, to a lesser extent, research. Early intervention in Catalonia, therefore, does not consist merely of what is done directly with the child. One might say there is one type of intervention which is more direct –that performed with the child- and another which is less direct –that which is carried out with the different agents involved with infants and young children.

Even so, it should be borne in mind that according to a study of the needs of the families in Catalonia conducted by the Disability and Quality of Life research group (Ramon Llull University) in 2010, parents insist on being able to have more contact with the professionals (Disability and Quality of Life; Educational Aspects, 2010) . The families are satisfied with the attention and care they receive from this service, but not with the amount of time dedicated to them as opposed to the child on its own, which confirms the results of a previous study (Giné et al., 2001).

According to Ruiz & Zaurín (2004), from the outset, Catalonia has been a pathbreaker in Spain in the way it has managed early intervention. It can be said that Catalonia now has an early intervention service provided by the early intervention centres that is well established, well regulated and highly regarded for the quality of the care it delivers (Vilaseca et al., 2004), although certain important limitations remain in the rural areas and in regard to certain needs, as well as, as just mentioned, in relation to direct intervention with the families.

Indeed, the measures that need to be taken to improve the service in the future and bring practice into line with the new perspectives on such work include: making the service more sensitive to the families' needs (opening times, etc.) and more flexible, including the possibility of home visits to contextualise better the advice given on child rearing; and, lastly, increasing the time devoted to the families, especially in the case of children who require it.

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# The Early-Aid-System in Germany

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Annette Hartung\*\*

Olaf Kraus de Camargo\*\*\*

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## 1. Families in need for support

*Mrs. W, a social pedagogue of an Early Intervention Center receives a phone call from Mrs. H. who works at the social service of the city. Mrs. H. wants to refer a four year old boy, L.K. for early intervention. She met the child and the mother the same day in her office on the occasion when Mrs. K applied for social assistance. Mrs. H. observed that the boy demonstrated behavioral problems, not being able to follow rules and seemed quite delayed in his language skills. On the phone, Mrs. H. has the impression that this child needs urgent intervention. Mrs. W. clarifies that such a referral needs to be initiated by the parents. As the mother is still in the office of Mrs. H., it is possible for her to talk directly with Mrs. W and initiate the referral process. Both agree with a home visit for the intake meeting during the following week.*

*Mrs. W lives with her two sons M. (12 years) and L. (4 years) in a condo located in the outskirts of town. The condo is doomed and will be torn down soon. Only two of the 16 apartments are still occupied. Many windows are broken, the area has an abandoned, ghostly aspect. When Mrs. W. arrives she is being expected by Mrs. K at the door. Although Mrs. K's name is not familiar to her, she recognizes the woman as one of a group of people, some of them homeless, that usually gather on the marketplace downtown. She seems to spend the major part of her days there. The apartment is in a neglected condition. Some of the cushions of the sofa are torn out, the broadloom carpet is full of dust that fills the air with each step. Mrs. K. points at L., who is hiding behind an armchair. Mrs. W. tries to approach him but he runs away and produces some unintelligible vocalizations. She tries to entice him with a toy that she brought with her and puts it on one of the chairs (she doesn't feel comfortable in putting them on the carpet). L. approaches her*

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running, grabs the toy and throws it across the living room. Mrs. W. decides that in these conditions it will be difficult to create a stimulating play atmosphere. She spends the rest of the visit explaining to Mrs. K. all the forms necessary to initiate the early intervention and asks if L. is attending a kindergarten. Mrs. K. answers that this is not the case and Mrs. W. has the impression that Mrs. K. herself has own learning difficulties or even a mental retardation. Mrs. W. offers to look at the possibility of registering L. into a kindergarten, as he is due to enter school in the following year. Mrs. K. is in agreement with this. Mrs. W. asks, if any other „services“ are involved at the moment with the family and as this is not the case she also offers to initiate an application for educational support at home. Mrs. K. is also in agreement with this suggestion and has no objection in involving the local children's aid society for those services.

In the following days Mrs. W. tries to find an adequate kindergarten for L.. She meets the staff of a nearby institution and they indicate to know L.: „he is frequently roaming through the neighborhood or the nearby industrial area and we saw him several times taking a nap lying in the ditch. He goes there probably when he gets tired.“ Nonetheless, this institution is not willing to offer a spot for L.. Eventually Mrs. W. is able to approach a kindergarten of the church and „talk them into“ accepting L. in their institution at least for the next three months. Mrs. W. reconnects with Mrs. H. informing her about the solution and requesting an additional support for integration of L. in the kindergarten, a so called „integration placement“. Mrs. H. denies that request based on the argumentation that in first place it will not be feasible to organize an additional support in such a short time frame and in second place, once the integration support is being granted, the early intervention will have to cease. As the early intervention is also home based and necessary for that family this would not be an desirable outcome. She suggests that Mrs. W. tries to arrange a continued „regular placement.“ Mrs. W. also calls the children's aid society and is informed that they are already aware of the case and that a social worker had been assigned to support Mrs. K. They agree on a case conference and decide that the social worker will focus in trying to find an adequate living space for Mrs. K. and her two sons to improve the hygienic conditions. Mrs. W. will continue with developmental support and find a definite kindergarten placement for L.

In the following days L. starts attending kindergarten and is being seen there on a regular basis by Mrs. W. In the first days he struggles with the rules and hygiene (initially he has such bad body odor that he needs to be bathed at the kindergarten) but during the subsequent days the situation stabilizes. L. adapts to the daily routine of the kindergarten and mostly respects the house rules. He also

*increases his vocabulary and his speech becomes clearer. During the home visits Mrs. W. observes that L.'s 12 year old brother functions as the main caregiver. He frequently spends time with L., reading books to him (mostly about dinosaurs and sea creatures) and tells him stories („scary stories“) he invents. L. is very attached to his older brother who is attending middle school successfully.*

*Mrs. W. is able to convince the kindergarten to maintain L.'s placement also after the summer vacation, as he will be going to school in the following year. The social worker is able to find a new apartment for the family and Mrs. K. moves into it with her two children. With the support of the social worker it is possible for Mrs. K. to maintain the new apartment clean. Nonetheless, she spends the most part of her days on the market place with her friends downtown, the care for the children occurs irregularly and she does not maintain a routine. Despite those conditions L. shows a nice progress in his development over the year and so Mrs. W. suggests that he should be placed in school as a regular pupil. She contacts the school authority but is informed that L. did not „pass“ the admission exam and will have to attend a special school for children with developmental delays and other special needs. Mrs. W. explains the trajectory and the substantial gains that had occurred during the last year and convinces the school board to allow L. to attend a regular school with additional support, in a so called „diagnostic and support class“ for children with less pronounced delays. She informs Mrs. K. of the „successful“ discussion with the school board but Mrs. K. is not satisfied at all and insists that her son attends the special school for developmentally delayed children. The advantages she sees are the easy transportation (pupils are picked up and brought home by bus) and that school has a whole day schedule, providing care for L. also during the afternoons. Mrs. W. accepts the mother's decision and early intervention ends, as usual, with school entry.*

## **2. The development of the legislative and institutional structure**

Today Germany is covered by a so called system of Early Childhood Intervention centres (=ECI of German “Frühfördereinrichtungen”). These centres offer family-centred help for children with developmental risks and their social environment. The law distinguishes two separate types of institutions within this system: the Interdisciplinary ECI centres and the social-paediatric centres (SPZ).

It was in the early seventies of the last century when the systematic development of institutions for Early Childhood Intervention was started. The creation of

the social-paediatric centres (SPZ) is very often linked to the name *Hellbrügge*. Under his leadership the first social-paediatric centre in Munich was founded in 1968 (Hellbrügge, 1981). The social-paediatric centres were planned to be supra-regional interdisciplinary ambulatory institutions of the health care system. In these centres teams of physicians, psychologists, pedagogues and therapists work in a hierarchical structure with a medical leadership. The recognition of this kind of health care service by German legislation took more time and occurred at the end of the eighties in the Fifth Book of Social Laws (SGB V). The care delivered at the social-paediatric centres is therefore a service paid for by the public and private health insurance companies.

The first ECI Centres were also founded in the early seventies (Sohns, 2000). The legislative establishment of these centres occurred after the „Recommendations of the German Council on Education“ (Speck, 1973) that influenced the third law modification of the Federal Law for Social Services (BSHG) in 1974. This law launched the foundation of numerous regional ECI centres in Germany. They showed multiple professional concepts and approaches but tried to reflect and satisfy the recommendations of the Council in the interpretation of Speck: The Intention of these recommendations was to create more possibilities for joint learning of children with and without disabilities to achieve integration inside and outside of schools and beyond this to deliver aid in the early stages of development during which disabilities are first manifested trying to prevent a later segregation at school. Early Childhood Intervention was therefore understood as a service for social integration. (Speck, 1996)

In the following decades over 1000 ECI centres were founded in Germany and literally covered the country with a system of Early Childhood Intervention. The professionals were in the majority pedagogues that delivered help to the children with disabilities and their families giving advice about activities of daily living and special pre-school education of the children (psycho pedagogic approach). Following the recommendations of the Council on Education the help was delivered mostly home-based within the living environment of the children and their families.

The further development of the ECI Centres was accompanied by conflicts on the professional and political level. The Federal Law for Social Services established in §40 that the professional resources for ECI should be measures of “remedial pedagogy”. In the consequence the financial resources for these measures had to be provided by the counties. Because of these circumstances the ECI



Centres were urged by many counties to employ pedagogical professionals. Especially in the medical community this development was criticized. Even the “Deutsche Ärztetag” as the highest professional organisation of physicians in Germany formulated a resolution in 1976 against the establishment of the Early Childhood Intervention Centres: “Contrary to the recommendation of the ‚German Council of Education‘ to establish new centres with pedagogical focus the ‚Deutsche Ärztetag‘ recommends the expansion of existing medical institutions. This way the tendency to unilateral orientation of Early Childhood Intervention measures can be avoided. Concomitantly higher effects could be obtained with less costs” (Berufsverband der Ärzte für Kinderheilkunde und Jugendmedizin Deutschlands, 1976, 846).

On the other hand the (pedagogical) Early Childhood Intervention Centres opposed medical hierarchical structures (obligatory medical direction) as established in the social-paediatric centres.

It seems obvious that these discussions, characterized by professional distrust and mutual rejection, were not favourable in developing interdisciplinary co-operations. In regions where these co-operations did occur they were based on personal relations and mutual respect between persons of different professional groups, especially with community physicians.

After the legal recognition of the pedagogical ECI Centres in 1974 it took until 1988 for the legislation to recognize the social paediatric centres (Gesundheitsreformgesetz, 1988). After that long period of non-coordinated parallel the relation of these both systems was structured in 1992: The treatment in social-paediatric centres “should be focussed on these children that cannot be cared for by adequate physicians or adequate Early Childhood Intervention centres because of the severity or the chronicity of their illness or impending illness. The social-paediatric centres shall co-operate closely with the involved physicians and Early Childhood Intervention centres” (GStruktG Art.1, § 119 SGB V and § 4 FrühV).

For the first time an interdisciplinary approach in Early Childhood Intervention was required by the “Law of Rehabilitation” (Rehabilitationsgesetz, 9<sup>th</sup> book of Social Laws, SGB IX) of 2001 and the “Ordinance of Early Childhood Intervention” (Frühförderungsverordnung FrühV) of 2003. By these laws Early Childhood Intervention Centres and SPZ are the only institutions who can offer Early Childhood Intervention measures. On an organisational level the SPZ are seen as supra-regional institutions (tertiary care) and the ECI Centres as local/

regional institutions. Both must employ an interdisciplinary team.

Today the (home and centre based) system of ECI is composed by about 130 SPZ and about 1.000 Early Childhood Intervention Centres. In the SPZ the interdisciplinary teams have mainly a diagnostic focus, but are also able to offer long-term centre-based care. Some of them also offer in-patient care (social-paediatric hospitals). On the other hand these centres are not able to offer home-based care. That means that the parents are obliged to take their children to the centres and sometimes endure long trips to receive adequate help. In second place the professionals at these centres have no possibility to evaluate the impact of environmental factors upon the functional health of their patients. The financing for these services is provided by the public health insurance.

In opposition to the SPZ the regional system of ECI centres is working as well centre-based as home-based. In most cases home-based means the actual home of the child, but in many centres (especially in East Germany) it also means working with the child in kindergarten. Traditionally in East Germany before 1990 the kindergartens were considered the main social environment for children. While the share of home-based care reached about 80% in 2000 the ongoing financial cuts reduced it to about 50% in 2008 (Engels et al., 2008). This means in the consequence that parents are increasingly obliged to take their children to the centres. In opposition to the social needs and scientific evidence an environmental-based approach is being continuously sacrificed by the financing institutions. These are in the case of ECI the counties. They are traditionally responsible for the pedagogical professionals. Accordingly the ECI Centres had hired mainly pedagogues. But due to differences between the states in the federal system of Germany one can also find ECI with interdisciplinary teams. In those the medical therapeutic professionals are mostly financed by the health insurances. In two of the 16 states ECI is integrated in SPZ and therefore does not offer home-based care. In one state the ECI Centres are mostly associated with remedial schools. Despite of the federal character of the law of rehabilitation (2001) it has not been possible to harmonize the regional differences.

### **3. The development of professional standards in ECI**

Accompanying the legislative development and the establishment of a financial basis for ECI institutions the last decades were marked by an intensive development of professional standards leading to important paradigmatic changes in the approach of children with disabilities and their families.

While in the early sixties and seventies of the last century this approach was based on the belief that disabilities may be compensated by intensive therapeutic interventions with the intention to „cure“ or „heal“ the disability (bio-medical concept), this view underwent major changes during the eighties (Rauh, 1985; Schlack, 1989). And while the former view was characterized by “technocratic and function-oriented therapeutic approaches” (Weiß et. al., 2004), professionals as well as parents felt uncomfortable with the strict separation of experts on one side and lay parents on the other side implied with that approach. This distribution of roles implied that parents had to follow the expert advices and were reduced to mere “co-therapists“ for their children (Holthaus, 1989). The technocratic approach was further challenged by the results of scientific research about the effects of therapeutic interventions in developmental disorders. These results can be summarized as showing very little effects of strict one-dimensional functional approaches but more promising results of approaches that were environment-based and individualized (Weiß et al., 2004). Following this philosophy the professional standards of former “Early Childhood Intervention” were developed to approaches that can better be described as “Early Aid” (in the following partly replacing the term ECI). They are characterized by a strong interdisciplinary and transdisciplinary work allowing an ecologic-systemic approach. Following the original aims of the legislation (“social integration“, German Council of Education) (Speck, 1973) an social-environment-centred system of Early Aid could be established (family-centred and kindergarten-centred).

The core principle of that approach is the recognition of the advantage of holistic procedures over uni- or multi-disciplinary therapeutic “interventions“ that do not take into account the family system and the environment of the child. Especially in the first phase of confrontation with the disability of their child parents are insecure, often shocked, experiencing feelings of being offended, blamed and ashamed. Associated with that emotional stress is the burden of the intensive daily routine of special care for the child, additional administrative issues and the many appointments filled with therapies or diagnostic procedures. The social context in many cases also suffers transformations. Less family members and friends tend to be available for help and support (Sohns, 2000). On the other hand the traumatized parents often hesitate to request professional help to deal with the many problems they are facing (Sohns, 2000). In such a situation it is in the interest of the child that the whole family – and in certain cases even other professionals involved with the child – receives support of professionals that can deal with the many emotional aspects of the special situation the family is living and offer appropriate information and advice.

On the contrary to the historic approach based on the role of parents being co-therapists receiving 2 orders“ from experts and having to “comply“; this new approach respects the autonomy of the child and the family. The responsibility for the actions to be taken remains within the family. Thus the family members and the child continue to be the “initiators“ based on the knowledge that self-initiated actions tend to be more productive and show longer lasting effects than externally imposed actions. In Early Aid the professional measures are therefore always aimed to support the initiative of the child and the family. This principle has been coined with the expression “Aiding for Self-Aid“

#### **4. New demands resulting of social transformations**

The necessity for such a transformation of professional standards derives also from the modifications of the kind of disabilities or indications for granting Early Aid. In the beginning the majority of children receiving “ECI“ had “classic disabilities“ in the sense of structural or functional defects or disturbances (Sohns, 2000). The percentage of children attended with these disabilities has been shrinking continuously over the last decades. The last epidemiological survey regarding Early Aid in Germany in 2001 analysed all institutions offering Early Aid in one state (Mecklenburg-Vorpommern) and can be considered representative for the German federation:

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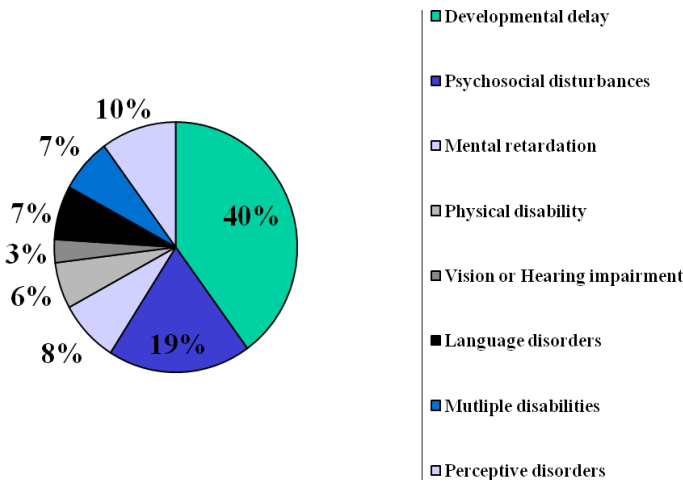
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Graph 1: Epidemiological Survey on Early Aid in Germany 2001



(Sohns, 2001)

This graph shows that children with physical, mental and multiple disabilities comprise only 20% of all children. The majority are children without clear-cut diagnoses. Nonetheless these children and their families are without doubt in need of support and care. In many of these cases it is still difficult (also due to the young age of the children) to decide if the cause of the disability is organic,

if the child shows initial symptoms of a mental retardation or if the difficulties are due to environmental factors delaying or inhibiting the development of that child. Therefore it is important to concentrate on the resources available in each child and each family and try to establish situations and attitudes that foster a healthy development.

To achieve this it is not sufficient to work only with the knowledge and the techniques of remedial pedagogy. Other qualifications become necessary and the knowledge of many disciplines is needed. In response to these requirements many Early Aid centres in Germany developed an interdisciplinary system of professionals working in teams, assuring this way a continuous cooperation between professionals of different disciplines (medical, pedagogic, psychological and therapeutic). In the actual legislation regarding rehabilitation (law of rehabilitation) all of the following and above discussed aspects can be found and are required for institutions of Early Aid: interdisciplinary, a holistic approach, social integration as a major goal and a preferred focus on preventive approaches (Sohns, 2002).

Many children that are identified during medical, psychological or educational assessments as “developmentally delayed“ do not present initially with all the possible contributing factors to that delay, especially when the environmental conditions are not known. Educational diagnostics is therefore always oriented towards the underlying conditions that may influence the development of resources for these children. To have this information it is always necessary to observe the development of the children in the follow-up. *Only after being admitted to the kindergarten and receiving early intervention, L. was able to show his potential and develop further. It also revealed the limitations of the different systems of their abilities to support him. On one side, his home and living conditions explain why, although probably having an average intelligence, L. was so behind in his language development. On the other side, this case example cannot explain why his older brother developed so differently; did he grew up in different, still more favorable conditions or is he more resilient or has he been assessed by different specialists at school entry that provided him with more adequate support?*

The above mentioned story is an example demonstrating which professionals can be involved in the support of a family with a vulnerable child and also which systems issues might arise in the collaboration of the involved professionals.

It also illustrates how developmental trajectories can be determined by system

rules and conditions. If it were the case that in Germany not only schools for children with special needs offer full-day schooling but also the regular schools, the probability that L. could have attended a regular school would certainly have been greater. On the other hand, in the case example many parties are quite satisfied with the schooling decision: The regular school is relieved in not having to care for another “difficult“ child, the special school is able to demonstrate demand and therefore the reason to continue existing and being funded and the mother is satisfied as the solution is more convenient for her own limitations and lifestyle.

This example also illustrates how early intervention and social work are closely related with each other. We observe a growing number of children growing up in social disadvantaged conditions, parents having to cope with higher demands on education, care and fostering of their children in an environment that at the same time has become much more restricted in developmental possibilities for children. Parents, and especially those with lower education, find themselves increasingly isolated in trying to tackle the modern demands on parenting skills while living without the relationship of a multi-generational family or the support a traditional village or ward structure would naturally offer. Many of them feel overwhelmed. It is necessary that early intervention measures take such constellations into account and offer support to address especially those social issues. Possible ways of support could be in empowering parents in their competence to request additional services as social work, daycare or kindergarten placements. In some case, as shown in the above example with L., certain tasks have to be assumed temporarily by a professional. Early Intervention encompasses therefore a broad field of activities and tasks.

## **5. The different tasks of Early Aid and the difficulties in realising them**

According to the holistic approach several different tasks have to be achieved by the interdisciplinary team. It starts with the important aspect of *Early Identification* of children in need of Early Aid, according with specific developmental risks. Different approaches are used to identify these children. The majority is seen during the regular developmental screenings performed by family doctors and paediatricians. If they suspect of the need of further diagnostic interventions they can refer the children to the SPZ or Early Aid-centres. Unfortunately the access to the SPZ is hindered by long waiting lists

(up to one year) and in many regions there are great distances to be covered by families without much financial possibilities. The access to the Early Aid-centres is dependent on the clearance of the request by social administration, and to the physicians of the public health service. Especially families from social disadvantaged segments of society are quite reluctant in complying with these formal requirements as they feel stigmatised by them. Therefore it has been proposed and formulated in the law of rehabilitation that the access to first visits in Early Aid centres should have a low threshold and allow worried parents to get help without bureaucratic barriers. The financing of such an “easy-entry“ still awaits a solution.

Another task is the *diagnostic part* in the process of Early Aid. Dependent on the individual circumstances and reported difficulties different professionals assess the child and the family. One of the professionals assumes the position of contact person with the family and gathers the results of home visit, interviews and assessments. After the conclusion of that part the interdisciplinary meeting takes place. In that meeting the desires and needs as well as the results of the professional assessments are discussed and result in an individualized planning of aids and therapies for child and family. This procedure should be oriented by the International Classification of Disability, Functioning and Health (Kraus-de-Camargo, 2007; World-Health-Organization, 2007). The finished plan has the function of a contract between the family and the Early Aid Centre, establishing goals to be achieved and the methods on which has been agreed on.

As the realization of the plan often requires the contact to other institutions and administrative organs as well as professionals outside the Early Aid centre it is important that the interdisciplinary team coordinates these contacts and cares for them in a network of cooperation. This *regional networking* is also an important task to guarantee an efficient work and should be supported adequately by the financing organs.

Regarding the methods, *intervention and education* of the child have the same status and importance as *advice and support* to the parents or other related persons. It is still very common that financing organs expect that aid should be a specific intervention performed on the child, oriented by the deficits that have been diagnosed and willing to pay only for these procedures that took place in presence of the child. This attitude turns it difficult to offer help to the families in a more flexible manner and according to their necessities. Especially with regard to the increase of children with developmental disorders or so



called “behavioural problems“ from social disadvantaged families it might be really more efficient to counsel the parents and other contact persons than to stigmatise the child as “disordered“ offering “therapy“. Another example could be parents in the period immediate after being informed about a significant disability or chronic illness of their child. It might be more efficient in the long term to invest in counselling of the parents in this early phase than to deliver several intensive developmental therapies. So, regarding the task of *taking action*, it is desirable that a high flexibility in offering the most urgent help, as seen by parents and professionals, is possible.

## **6. Development of a “complex aid” - present and future issues**

The law of rehabilitation introduced the legal term of a “complex aid“. The intention of this expression is to describe the complex interdisciplinary cooperation between pedagogic and medical-therapeutic measures necessary to support children with disabilities and their families. It offers the chance to develop more effective and more individualized approaches for the growing number of children with developmental risks. As many of these children grow up in social disadvantaged situations it will be necessary to take the findings of neuropsychological research regarding resilience and vulnerability into account. On the other hand the institutions of Early Aid are facing the challenge of restrictive financing and unmotivated feelings of different professionals competing one against another instead of cooperating. It will be necessary that the interdisciplinary teams learn to develop transdisciplinary competencies to face the challenges ahead. At the moment many of them are still working as multidisciplinary teams with many different professionals in contact with one child or one family. With an increased transdisciplinary competence it will be possible to reduce the number of contact persons per family but it will be necessary that the team cooperates more closely and the different professionals support one another.

The practical experience of how the administration of the districts/counties (responsible for financing pedagogic support) and of the health insurance companies (responsible for financing medical-therapeutic aid) are complying with the law since 2001 is disappointing. It seems that administrative organs face great difficulties in developing a financing model incorporating these classical distinct types of aid. The primary interest seems to be to delegate

the maximum of responsibilities to the other administrative organ instead of cooperating one with another. Professionals and experts for Early Aid have not been invited to take part at any of the official meetings that were held at administrative and political level to discuss possible solutions for the financial questions. In 14 of the 16 states could be agreed upon a so called “framework of agreement” for financing this “complex aid”. The content of these agreements shows in the majority of cases a great distance to what was the original intention of the law. They propose multiple diagnostic procedures, hinder the interdisciplinary cooperation and do not finance the important aspect of counselling and supporting the parents. But at least these agreements achieve a more formal cooperation between pedagogues in Early Aid centres and the family physicians. In those states (Bavaria and North Rhine-Westphalia) where are already practical experiences with the framework agreements (in terms of formal contracts between Early Aid centres and the social administrations of the counties and health insurances) the Early Aid centres are suffering massive financial cutbacks, reduction of the family centred work (Bavaria) or lack of financing qualified professionals (NRW). Among the professionals the hope persists that with a broader application of the “complex aid” the structural and financial demands will show more clearly that corrections can be made to the framework agreements to allow an adequate financing of the good intentions reflected in the law of rehabilitation. In the near future it might be necessary that the federal government takes responsibility for the law it created specifying more precisely the administrative cooperation between social administration and health insurance.

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# Early childhood Intervention in Lithuania: Organisation and Challenges

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## 1. The structure and organisation of Early Childhood Intervention

Early childhood intervention system in Lithuania for very young children (0-3) in need and their families started to be established in 1996 on behalf of health care system supplementing the educational support for children from 3 years old to school age (7 years) provided in kindergartens theretofore. Activity of early childhood intervention services (ECI) in LT is so far regulated by the documents of the Health Care Ministry and it is groundlessly considered as a treatment (the 2000 12 14 Order No 728 of the Health Care Minister of the Republic of Lithuania, 2001). ECI play the role of service of *disability prevention* and *disability treatment*. Regulations say: “Early intervention for children at risk or with developmental disorders – *health care service*, which ensures early enough *identification* of disorders, early *multi-professional support* for children and their families. This ensures primary, secondary and tertiary prevention, intervention and integration into society and educational system”... “Early intervention service is organised on the principle of teamwork”. Team consists of a social paediatrician (coordinator of ECI team), a psychologist, a speech therapist, a physiotherapist, a special pedagogue, a social pedagogue/worker, an ergotherapist, a nurse”.

ECI service is provided for families with children at bio-psycho-social risk and/or children with developmental disorders from 0 to 3 years of age mainly, or till a child enters the educational system (e.g. kindergarten, etc.). In Lithuania ~5% of all children population is involved into ECI. 38 multi-professional ECI teams at local level (1 team for ~10.000 children population) and 2 ECI centres at national level are offered to those children. “Life-line” of a very young child at risk or a child with developmental disorders in Lithuania is showed in table 1.

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Table 1: ‘Life- line’ of child at risk / with developmental disorders till school in Lithuania

Place	Age	Responsibility
Hospital, home	From birth till first years	<b>Health.</b> Paediatricians and nurses are the first to intervene.
Early Intervention Services at local level (n=38)	In case of developmental risk/ disorders from 0 till 3/7 years of age.	<b>Health.</b> Paediatrician is the coordinator of multi-professional team. Team consists of a social paediatrician, a psychologist, a speech therapist, a physiotherapist, a special pedagogue, a social pedagogue/worker, an ergotherapist, a nurse.
Early Intervention centres at national level (n=2)	For complicated cases, family and professional counselling, courses for professionals and parents, in-service training etc.	
Pedagogical Psychological Services at local level (n=55)	From 2 years (2-18) of age.	<b>Education.</b> PPS provide case studies, assessment, recommendations for support. Family has a right to choose the institution and a type of support.
PP Centre at national level (n=1)		
Mainstream kindergarten	2-6 years of age.	<b>Education.</b> Each kindergarten has a speech therapist, some of them + social pedagogue, physiotherapist.
Specialised groups in mainstream kindergarten	For children with profound disabilities.	<b>Education.</b> A speech therapist, a special pedagogue, a physiotherapist etc., a team of professionals or one of professionals (depends on specialisation of support).
Specialised educational centres (for children with multi-disabilities; visual impairments; hearing impairments; autistic children).	From 2 years of age (kindergarten; including school).	<b>Education.</b> Team of professionals: a speech therapist, a physiotherapist, a social pedagogue, a pre-school teacher.

([www.european-agency.org](http://www.european-agency.org))

ECI is provided mainly in ECI centres at local level. When a child moves to educational system (mainly from 3 years of age), the kindergarten is responsible for the individual support for a child in need. Majority of mainstream kindergartens have a speech therapist; some of them have a social pedagogue and/or a physiotherapist. Depending on the needs of children, there are specialised educational centres (only a few) with multi-professional teams. Most kindergartens are day care institutions funded from a budget with a small family contribution.

ECI services work in close cooperation with the paediatric system, with pedagogical psychological services, social and educational services. To date, ECI system in LT has been centre based and city-centred mostly focused on a therapy support and informal mother's education regarding child's developmental issues. Early intervention services are funded by health assurance funds, therefore the service for families and their children in need is free of charge. Family doctors / paediatricians / neurologists are responsible for referral to ECI. The referral system is flexible – children can be involved into ECI programme because of different risk factors (e.g. prematurity, motor developmental delay, social risk etc.) as well as developmental disorders even if they are not formally fixed. There is a possibility for families to apply for the ECI themselves if urgent questions concerning the development of a child arise.

The concrete support for the child is regulated by the Order of the Health Care Minister (2001). The type of support depends on the situation and need of a child and a family. In case when the risk factors (biological, psychological, social) are evident, the consultations are offered and the child is followed up by the ECI team (from time to time they meet together to evaluate the situation). If the developmental delay, difficulties or mild disorder are noticed (formally can be stated or not), a child can receive up to 18 therapy sessions a year (e.g. 18 speech therapies, 18 physiotherapies etc., depending on the need). Children with moderate/severe disorders (with statements) can receive up to 40 therapy sessions a year. Individual therapies are always combined with team meetings, discussions etc. The team meetings are usually organised once a week (it depends on the team decision) in order to discuss the complicated situation etc. In a situation of social risk, mental illness of parents etc., a social worker from ECI service visits a child and his/her family at home once a week. The workload of ECI professionals is 4 children a day, but in reality they meet with 7-8 children. The ECI support is operative and the waiting list for the support is very short. Depending on the situation and the needs, a child and a family can receive support immediately.

## 2. Parent participation in Early Childhood Intervention

Parents are directly involved in the ECI process, they stay with their child during the therapy. However, full participation of parents and professional-parents collaboration is still a challenging issue of the ECI system. The opinions of parents and professionals about various aspects of collaboration: parents' satisfaction with ECI, collaboration between parents and professionals, organisational priorities of ECI activity, the nature of child's recognition, professional improvement, have been analysed in depth in 2003 (Ališauskienė, 2003). Parents' and professionals' opinions showed that majority of families, using ECI service with their children, are poorly informed about the work of ECI and the role of professionals and themselves as the parents, and do not participate in ECI teamwork. The emphasis on disabilities/disorders of a child and purposefulness of the professional improvement of the therapies, common for professionals, showed predominating medical approach. The ascertained tendencies of predisposition to collaborate showed that parents' and ECI professionals' opinions on the essential questions about the ECI activity were similar. In specifying the priorities of collaboration, opinions of the respondents of various groups differed. The diversity of opinions was ascertained both in parents' and professionals' groups, and it can be determined by a limited experience of ECI teamwork, unformed traditions of early intervention, lack of methodological background of activity and lack of systemic approach towards a child. On the other hand, parents lack of information about their role in the ECI, about support and relationship with professionals. Due to personal and usually negative experience of communication with specialists, parents tend to feel guilty and to accept conditions, proposed by specialists, without stipulation.

Parental *satisfaction* with ECI has been identified as one of the most important indicators of quality in early intervention (Ališauskienė, 2004). 'Satisfaction' with ECI is a complex concept and is often understood and interpreted differently by parents or professionals and so the following aspects of satisfaction have been analysed: the way parents evaluate the model of intervention; the support provided to parents and a child; the relationship between parents and professionals; accessibility of services, the organisation of work etc. The *European Parental Satisfaction Scale about Early Intervention* was used. Parents (N=160) bringing up children with special needs attending seven ECI services in Lithuania took part in the research project. The results of the investigation showed that, overall, parents attending ECI services with their children

positively evaluate the quality of services provided in Lithuania. According to parents' opinion, intervention towards a child in ECI in Lithuania is well provided. Proper ways of communication with a child prevail; professionals pay much attention to a child and his/her behavioural problems, stimulation of motor development etc.

Parents receiving ECI in Lithuania are less satisfied with the support to parents and factors of social environment, namely: including other family members and relatives, as well as educational and social institutions into ECI, psychosocial support to siblings and other family members, organising parents' groups, information about financial support. Insufficient experience in providing social services in Lithuania, traditions, professionals' attitudes and competences may determine unfavourable social situation in some of the ECI areas. Parents unfavourably evaluate relationship with professionals. They are not satisfied that they are hardly included into mutual evaluation of the situation of a child's development, and into problem solving concerning the child's education; moreover, sometimes parents don't have the necessary information about their and professionals' functions in the service, they cannot or are afraid to discuss and express criticism to the professionals. Limited parental satisfaction with the model of intervention is most probably determined by the prevailing specialised medical approach, when professionals still play the role of experts in the process of ECI towards a child, and when intervention is oriented towards therapies rather than systemic intervention, which includes family members, and stimulates social competences of a child and a family.

The analysis of ECI situation helps to understand that the prevailing traditional orientation to ECI is inappropriate for family, but the challenges admitted by the professionals show the latent striving towards positive changes in this sphere of ECI. New worldwide methodological issues of ECI influence the perceptible changes of ECI in Lithuania. There is a slight tendency from a *deficit model* focused on child's disorder, to *social models*, which are orientated to the systemic support for a child and family, positive development of parents' and children's relationship, the involvement of parents into the process of ECI, the creation of links between a family and a community etc. ECI system in LT is more and more influenced by the ideas of new research of the "second generation" and "third generation" which are based on the principles of integration, inclusion, participation, interdisciplinary, systemic issue, quality of service, etc. (Ališauskienė, 2005).



### **3. The background of Early Childhood Intervention system**

#### **3.1 The Legal situation**

The implementation of the ECI system started in 1996 and the services are provided at a local level (for every day therapies and support) and at national level (for complicated cases, family and professional counselling, courses, in-service training etc.). ECI in LT is regulated by the Order of the Health Care Minister of the Republic of Lithuania (2001), Law on Special Education, 1998; Law of Education, 2004 (both not mentioned specifically in the references) other documents (e. g. the governmental regulations and orders on meeting the special educational needs, etc.). The new official document (not mentioned specifically in the references) *“The description of the model ‘Improvement of living and educational conditions of children from birth till school enter”* approved by the Ministry of Education in 2009 is focused on vulnerable young children living in social risk environments, especially in rural regions. According to the official document (the 2000 12 14 Order No 728 of the Health Care Minister of the Republic of Lithuania, 2001). ECI in LT reaches all children and families in need (in a case of bio- psycho-social risk or identified disorder every child should be seen by a paediatrician/family doctor/neurologist and sent to the ECI within the first twelve months of life). In LT the ECI system is focused on urban areas; in rural areas there is a shortage of services (ECI, kindergartens, professionals) for young children with developmental difficulties and their families. In order to guarantee the access to the required information to families, the paediatricians / family doctors should take the main responsibility for it. Much more attention should be paid towards the access of required information regarding ECI not only for families, but for professionals of other sectors as well. The health care system takes very much into account the importance of the child’s first year in detecting delays and difficulties.

ECI services and centres are decentralised; they are as close as possible to the families. However, the quality of service depends on a geographical location. There is a lack of services or they are of lower quality in rural areas. Services are provided in the city centres; there is a lack of mobile teams and other alternative services in a family context. The overlaps of support are more or less under control – if a child gets service in a kindergarten, he/she doesn’t get any support in the ECI system.

Regular meetings between professionals and families are organized in ECI services, kindergartens, centres. Families are involved to a certain degree (but not enough) in the setting up and implementation of the Individual plan. Formally professionals

recognise parents as partners in the support process, but in practice families should be involved into the ECI process much more actively. Families become more active, they more and more often participate in the decision making and implementation of the ECI plan, but participation of families vary according to the competences, management and culture of the team/professionals. To have a key person in a team is not obligatory; it is a team decision. Families have a right to receive training upon request; family (usually mothers) training is mostly informal - as a sharing of experience/showing exercises (therapies) etc. There are no specialised training programmes for families (with exception of project based programmes on parenthood education).

Professional teams work closely in the centres, regular and stable interdisciplinary team meetings are organized. There are conditions for engagement of team members (e.g. common language, time, etc.). There are clearly defined roles and responsibilities in a team.

Early detection and referral are implemented in order to avoid gaps and delays that affect further intervention. Developmental screening procedures are not provided for all children, but are going to be implemented soon. Formally the support continues – it does not stop when a child moves to another setting (kindergarten), but in reality the support for pre-school children (not for very young children in kindergarten) is a priority. There is no official requirement that children coming from the ECI services are given priority places in their kindergarten/preschool settings, but in reality it happens.

### **3.2 Professional qualification requirements**

In order to be a part of the ECI professional team the bachelor degree is required, master degree is recommended. Quality assurance of the ECI teamwork is implemented through in-service training, case studies, team meetings, specialised courses, seminars, etc. Modules on ECI are included into the BA and MA programmes for most professionals in a team (e.g. speech therapists, special pedagogues, physiotherapists). Programme 'Co-ordination of special needs education' on MA level as a common background for professionals from different professional fields (working in ECI, PPS: Pedagogical Psychological Service etc.) is offered. MA program on ECI is in preparation.

New ideas of social participation, empowerment and inclusive education encouraged the main changes of Lithuanian educational policy, practice and professional training of future professionals (special pedagogues, speech

therapists, social pedagogues, physiotherapists etc.) working with vulnerable persons in the last 20 years. The main changes, for example, for professional training of special pedagogue in the last 20 years see in table 2.

Table 2: Changes in professional training of special pedagogues

Aspects	Comparison of changed aspects	
	before	currently
Studies	“Oligophreno”-pedagogy	Special education (with speech therapy, physiotherapy qualifications)
Qualification	Special School Teacher	Special pedagogue (with qualification of speech therapist/ physiotherapist)
Target group	Children with mental retardation/ <i>homogeneous</i> group	Children at risk/with various developmental disorders and SEN/ <i>heterogeneous</i> group
Institution to work	To work in specialised/special school	To work in mainstream as well as in specialised institutions ( including ECI)
Interaction	One direction: teacher → child	Mutual interaction: teacher ↔ child ↔ family
Aim of education	Transfer knowledge to a child and develop cognitive skills	Develop social competences of a child
Environment	Structured, segregative	Flexible, inclusive
Focus	Disorder/disability	SEN/individual needs/ vulnerability/resources/ participation, empowerment/ resilience
Role	To be an expert	Teamwork/cooperation with other partners and families

The mentioned changes are closely connected with theoretical methodological, political issues. They influence the educational practice as well as professional training.

### **3.3 Scientific research**

In the last decade the scientific research in the sphere of ECI was as active as never before in Lithuania. We checked the main scientific periodical in the field „Specialusis ugdymas“/Special education” for the last 10 year period searching for articles where the studies on ECI would be presented. More than 20 articles on ECI were found (see table 3).

Table 3: Publication samples on ECI (not mentioned specifically in the references)

Title, author, source	Abstract	Main focus
<p><i>Perspective of changes in educational reality of early intervention services.</i> S. Ališauskienė Specialusis ugdymas, 2001/2/5</p>	<p>The article deals with the document “Requirements for Organizational Principles, Description and Provision of the 2nd and the 3rd Level Service of EI for Children with Developmental Disorders” (order No 728 issued by the Lithuanian Ministry of Health, 14 12 2001, Vilnius). It relates to the situation in Lithuania while creating the document. Methodological basis of qualitative analysis of the document using analysis of the text and reception study according to expert methodology enabled to identify the prospects and changes of educational reality in early intervention services and helped to establish the possible tendencies referring to the document perception.</p>	<p>The analysis of legal regulation of ECI in a country.</p>
<p><i>The development of emotional reactions of deprived infants</i> L.Radzevičienė, J. Ruškus Specialusis ugdymas, 2001/2/5</p>	<p>The aim of our research is to reveal effectiveness of pedagogical input for emotional reactions according to the structural and dynamical aspects. 17 infants from 15 to 24 months of age at Infant Home were observed and took part in the 9 months pedagogical experiment. Expression of emotional behaviour was analyzed according to the aspects of age, gender, level of psychosocial development, content of education, dynamics of emotional reactions and somatic stage of the children.</p>	<p>The pedagogical experiment on emotional behaviour of young children living without a family.</p>
<p><i>Analysis Of Psychosocial Situation Of Parents Who Have A Premature Child.</i> S. Ališauskienė, J. Ruškus Specialusis ugdymas, 2002/1/6</p>	<p>The analysis of psychosocial situation of parents who bring up a premature child is presented. The model of “second generation research”, which deals with a move from a child’s individual cognition principles towards family perception rules, forms the basis of the methodological investigation. From the standpoint of situational adaptation, the authors intended to identify parents’ with a premature child, outlook and to reveal the link between parents’ susceptibilities and family demographic factors. Knowing parents’ individuality better would assist ECI specialists to model psychosocial situations of parents having a premature child and help to find out proper directions of support, communication and cooperation, thereby to originate the educational environment of ECI not only for children but their families as well.</p>	<p>The analysis of psychosocial situation of parents with premature child.</p>

<p><i>Predisposition of Collaboration Between Parents and Professionals</i> S. Ališauskienė Specialiusis ugdymas, 2003/1/8</p>	<p>The survey data-based article presents the results of predisposition of collaboration between parents and ECI professionals. The author of the research intended to assess professionals' and parents' predisposition to collaborate in the situation of early intervention. Taking into account the aim of the descriptive research - systemic qualitative quantitative description of the object, the methodology of the evaluation of the parents' and professionals' attitudes towards the collaboration, based upon the relation between the preliminary opinion and attitude, has been given. The analysis of the situation helps to understand that the traditional orientation to early intervention, prevailing in the ECI, is <u>inadequate</u> to a family, but the comments of professionals showed latently existing striving for changes.</p>	<p>The assessment of predisposition of collaboration between parents and the ECI professionals.</p>
<p><i>Intervention of Emotional Development and Behaviour Disorders of Pre-School Children</i> I. Kaffemanienė, V. Tereikienė Specialiusis ugdymas, 2003/1/8</p>	<p>The article discusses the effectiveness of intervention for pre-school children with emotional and behaviour disorders. The research proved that effective results could be achieved if not only a child but all his/her family actively participated in ECI process. The present boundaries of the ECI activity guarantee efficient though short pedagogical and psychological support to a child and his/her family; nevertheless, its effect could be more enduring.</p>	<p>The application of intervention for young children with behavioural disorders, involving family members.</p>
<p><i>Construction of Model of Collaboration between Professionals and Parents: Methodology and Reflective Practice.</i> S. Ališauskienė Specialiusis ugdymas, 2003/2/9</p>	<p>In the article the process of the construction of the model of ECI collaboration with parents has been analyzed: empirical and methodological basis is revealed, the professionals' predisposition to collaborate with parents in a preliminary stage of model construction has been evaluated, professionals' and parents' discussions and interviews with professionals have been assessed, the changes of ECI professionals' predisposition to collaborate with parents have been analyzed, the criteria of the empirically created model have been distinguished and tested. The process of model construction, based upon unanimous systemic methodology, may be tested, modified and transferred to another educational environment.</p>	<p>The construction of the collaboration model between parents and ECI professionals.</p>

<p><i>Parental Satisfaction About Early Intervention: Comparative Analysis of the Situation.</i> S. Ališauskienė, E. Seivenytė Specialusis ugdymas, 2004/1/10</p>	<p>The article analyses satisfaction with ECI of parents, bringing up children with special needs. The following aspects have been analyzed: the way parents evaluate the model of intervention, support to parents and a child, relationship between parents and professionals, accessibility of services and organization of work etc. <i>European Parental Satisfaction Scale about Early Intervention</i> has been used. The results of the investigation showed that parents, receiving ECI in LT evaluate the quality of service provided quite favourably. <i>Intervention towards a child</i>, i.e. professionals' competence of intervention towards a child, attention to abilities and developmental problems of a child and his/her individual needs is evaluated most favourably. The accessibility of services and the organization of work satisfy the needs. Parents are less satisfied with factors of creation of a social environment, the model of intervention and the relationship between professionals and parents.</p>	<p>The analysis of parental satisfaction with ECI.</p>
<p><i>The Investigation of the Family Having a Handicapped Child (A Case Study).</i> J. Ruškus, D. Gerulaitis, A. Vaitkevičienė Specialusis ugdymas, 2004/2/11</p>	<p>The research of the family was based on semi structured interviews: a plan with key notes was made (e.g. <i>situation „now and here“; focus on the past; waiting for a child; birth of a child; the first year of a child; noticing the handicap; child until 3; back to situation „now and here“; future hopes</i>, etc.). It was found that the family with a handicapped child had been involved in a series of struggles. Research identified some empowering, „strong“ (successful coping strategies) and distressing, „weak“ elements in family life and experience with a handicapped child: <i>family's microclimate marked by ambivalence; relation dichotomy between parents and a healthy child; controversial relations between healthy and disabled kids (siblings); changes in leisure content (before and after recognizing child's disability); contraction of social network (after recognizing child's disability); indetermination of family's domestic well-being</i>; etc.</p>	<p>The case study of family in a disability situation focused on empowerment.</p>

<p><i>Interpretation of the Perception of Social Risk in a Pre-School Educational Institution.</i> S. Ališauskienė Specialiusis ugdymas, 2005/1/12</p>	<p>The research is based on the idea to encourage processes of empowering vulnerable families as well as of their social resilience, while identifying and concentrating on internal and external resources, helping to create strategies of overcoming psychosocial problems. The aim of the research was to identify the social risks and the protective factors, which could help to inhibit the way to secondary problems of social nature in families.</p>	<p>The study based on idea to recognise social risks as early as possible and to encourage processes of empowering vulnerable families.</p>
<p>The Influence of Early Rehabilitation on the Motor Development of Infants D. Mockevičienė Specialiusis ugdymas, 2005/2/13</p>	<p>The urgency of the theme has enabled to formulate the problem question: can purposeful and systematic education influence the development of impaired movements more if it begins in the early period of infancy? Active participation of parents in the investigation helped to create better contacts between a professional and parents, the atmosphere of trust that is very important for the professional's work with a family and with an infant. Educational experiment was performed according to the programme of education, individually tailored for the infant according to the age of complex motor development.</p>	<p>The pedagogical experiment with applied strategies for stimulation of motor development of young children, involving family members.</p>
<p><i>The Effect of Early Physiotherapy on Psychomotor Development of Premature Babies Raised in Families and Care Homes.</i> E. Griniienė, K. Gelžinytė Specialiusis ugdymas, 2006/1/14</p>	<p>The aim of the research was to examine psychomotor development of premature babies by estimating the effect of different social environments (raised in families and care homes) and efficiency of physiotherapy in stimulating psychomotor development. The conclusion: psychomotor development of examined babies was stimulated by applying physiotherapy in the early age. Psychomotor development of babies, raised in families was faster. Presumably parents influence their babies' psychomotor development not only by stimulating their senses, but also by affecting their perception and social development.</p>	<p>The study on psychomotor development of premature babies living in different environments.</p>



<p><i>Early Childhood Intervention in Lithuania in European Context</i> S. Ališauskienė Specialiųjų ugdymų, 2007/1/16</p>	<p>The aim of the article is to reveal the situation of ECI in LT in the context of new recommendations of European Agency. The main results and findings from the study are presented in the article in the following sequence: methodological-theoretical approaches of ECI and its evolution, findings on collaboration in ECI between parents and professionals as well as parental satisfaction with ECI in Lithuania; results of assessed and compared ECI situation in Lithuania and other European countries.</p>	<p>The comparative study on ECI in LT in European context.</p>
<p><i>Ecological Approach in meeting Special Needs of Early Age and Pre-school Children.</i> S. Ališauskienė, J. Mikalajūnienė, D. Čegyė Specialiųjų ugdymų, 2007/2/17</p>	<p>Theoretical analysis of the conception of ecological systems model and its expression in the official documents as well as the changes in the process of identification and assessment of children's special needs/special educational needs were analysed and presented in the article. In the empirical part of the paper, professional priorities in the child's assessment and education, parents' preparedness to share information with professionals about their child, priorities of ecological approach used, as well as attitudes towards a child in educational practice were analysed and described.</p>	<p>The study focused on the extent to which the ecological systemic model is used in ECI/pre-school education.</p>
<p><i>Analysis of the Content of Professional Training in the Field</i> S. Ališauskienė, D. Čegyė Specialiųjų ugdymų, 2008/2/19</p>	<p>The paper presents the research, the aim of which was to evaluate the content of professional training of professionals working in the field of early childhood intervention (ECI) in Lithuania with regard to European ECI professional training program. Research data showed that the content of training various professionals to work in the sphere of ECI is geared towards the field in which they work and is directly connected with speech therapists and special pedagogues; they have more knowledge in the sphere of recognition/evaluation, specific functions and personal competences. In Lithuanian professional training content, more than in other European countries, the area of recognition/evaluation is predominant, emphasising support for a child.</p>	<p>The analysis of ECI professional training content.</p>
<p><i>Collaboration of Team members Providing Early Support for the Child and the Family: a Case study</i> D. Kairienė Specialiųjų ugdymų, 2010/1/22</p>	<p>The article introduces the structure of the concept of collaboration in providing early support for a child and a family from the professional team members' point-of-view. The case study of a team work is presented. The research aims to provide answers to the following problem questions: <i>How do the members of the team understand collaboration? What structural components make up the concept of collaboration? What theoretical prospects are collaboration practices based upon and what are its development opportunities?</i></p>	<p>The case study focused on the collaborative culture in ECI team.</p>

## **4. Current evaluation of Early Childhood Intervention system**

### **4.1 Strengths and Challenges**

Taking into account the recommendations of European Agency for Development in Special Needs Education (2005; 2010) according to the project “Early Childhood Intervention” (in which 5 main aspects have been analysed: *availability* - ECI should reach all children and families in need; *proximity* - support near a place and near a person; *affordability* - cost free services/provision; *interdisciplinary working* - involves professionals from various disciplines; *diversity* - health, education, social sectors share responsibilities) and the results of recent investigation in Lithuania, the comparison has been accomplished. It is evident that the ECI system in Lithuania is functional and relevant to the main aspects analysed, on the other hand, there are areas to be improved.

### **4.2 Positive aspects**

- Functional ECI system ensures that no child in special need from birth is left without the support
- ECI is centre-based service
- ECI provision is free of charge
- ECI is available for families in most cities and towns
- Professionals accept the idea of cooperation with families and within a team
- Teams of professionals are multi-professional and stable enough
- Formally the support continues – it doesn’t stop when a child is moving to another setting (e.g. kindergarten, etc.)
- The net of qualified and well equipped PPS with the function of co-ordination among educational settings is implemented

### **4.2 Challenges**

- Lack of co-ordination among health, education, social sectors
- Unequal quality / lack of service in rural areas
- Need for mobile teams or alternative support

- No clear definition of target groups
- Lack of system of primary screening for all children
- Not enough orientation to a family and child support in a family context
- Not enough attention to the development of Individual Plans
- Lack of in-service training for EIS professionals
- Professionals working in PPS need specialised training on how to recognise, identify and meet the individual needs of a very young child at risk/with developmental disorders/SEN and his /her family.
- Need for new study programmes for professional qualifications.

#### **4.3 What has been done recently?**

- According to Governmental Programme for 2008-2012, the official document has been prepared and approved in 2009 by the Ministry of Education: “The description of the model Improvement of living and educational conditions of children from birth till they enter school”.
- The Programme of In-service training (improvement of ECI professional qualifications) for PPS professionals and ECI Guidelines has been prepared.
- The supplementary ECI models have been developed (for mobile teams, multifunctional centres etc.)

#### **4.4 What is next?**

In order to guarantee the availability of ECI in rural areas, and to focus on vulnerable children in vulnerable families and to prevent social risks in the area, it was agreed with the Ministry of Education to supplement the existing system of ECI on behalf of health care system and educational system (kindergartens, specialised centres, etc.) – as of 2009, to initiate a new professional team, responsible for ECI in PPS (Pedagogical Psychological Service) and to supplement ECI system with a home-based / alternative service (a child in a family-orientated mobile team support). The presented ideas have been recently included into the National Programme for the Provision for Special Needs and will be implemented in the nearest future, starting from the professional training. The recommendations for ECI model improvement in LT see in table 4.

Table 4: Recommendations for ECI model supplement in LT

The type of Service (0-4 m. children till entering the educational setting)	Now available Health care/ In II & III level of health care services	Recommended to supplement Coordinated educational, social and health services
Service	Early Intervention Services	Mobile ECI integrated into PPS/ multi-functional centres etc.
Target group	Children at risk (biological -psychological-social) Children with identified disorders/disabilities	Children at risk (biological -psychological-social) and their families Children with special educational needs and their families
The population covered	Town population	For all population. Priority to children and families in rural regions/areas
Support	Therapy orientated support	Child in a family /Family orientated support /Educational and Social support
Professionals	Medical doctor (coordinator) Psychologist, speech therapist, physiotherapist, social worker etc.	At least 1 professional from PPS (psychologist/social pedagogue/ speech therapist/special pedagogue) is responsible for ECI (mostly home based support); Close connections and cooperation with PPS team.
Minimal requirements for professional qualification	The introductory course of Social paediatrics for paediatricians	The professionals providing mobile / home based support need to have a bachelor degree (MA degree is recommended) and the obligatory specialised training in ECI of 6 ECTS, 32 h. Specialised course of at least 1 ECTS is obligatory for every professional in a PPS team.
Referral to service	Family doctors/ paediatricians/neurologist	Paediatricians, family doctors, local social worker, etc.
Links with other services	With paediatricians, family doctors, neurologists, PPS etc.	With local social workers, paediatricians, family doctors, Children rights protection Services, other social services, ECI, educational institutions.

The recommendations are accepted by the Ministry of Education and the proposals for supplementary ECI model will be implemented soon.

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# Early Childhood Intervention in Spain: Standard Needs and Changes

Pilar Gutiérrez\*

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## 1. Introduction

Early childhood intervention (ECI) is a model of action for early childhood that is still in the process of consolidation as a scientific discipline. In Spain activity began in this area in the 1970s. At the outset, early childhood intervention (early stimulation) was understood as a form of treatment to be applied in the first years of life, which sought to maximise the child's physical and intellectual possibilities. The philosophy was to intervene in the child's problems and needs as soon as possible and with the family's participation in the process of rehabilitation and improvement of the child's abilities.

## 2. National ECI System

### 2.1 Structure

The Spanish population in January 2005 was 45,108,530 people, with approximately 6% in the age group of 0 to 6 years or those that are affected by ECI (around 2,650,000 children). The prevalence of children with limitations in Spain was 2.24%, or around 8,998 children. The rate estimated in early childhood intervention according to National Statistics Institute (INE) data is between 2.5% and 4% of the population between 0 and 6 years of age.

Spain's administrative structure, with 17 autonomous communities, has resulted in three types of services related to early childhood intervention: healthcare, social services and education. This division has existed both historically and in the current situation.

The very diverse nature of their practices leads to difficulties, such as coordination problems between services, continuity of care and intervention in children (there are differences between each autonomous community), types

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of intervention, information, legal and administrative requirements for access to services, etc.

## **2.2 Legal Situation: Applicable Legislation Legislative and Regulatory Aspects**

For the creation, development and general adoption of any system of care for children, a legal framework is necessary to establish, structure and regulate its operation and development. Spain has adopted numerous international regulations that have promoted the development of early intervention (Declaration of the Rights of the Child, UN, 1959; Declaration on the Rights of Mentally Retarded Persons, UN 1971; Declaration of Alma-Ata of the UN of 1978; World Programme of Action Concerning Disabled Persons, UN 1982; European Charter of Children's Rights 1992; European Convention on the Exercise of Children's Rights, 26 January 1996, etc.)

In Spain, this legal framework is limited and recent. It began with the recognition of the rights of the child. This first recognition generated different changes that gave rise to a new model of care for children.

- The Spanish Constitution of 1978
- Law on Social Integration of the Disabled (LISMI), of 1982
- Organic Law Regulating the Right to Education, of 1985
- General Law on Health, of 1986
- Organic Law on General Regulation of the Education System (LOGSE) 1990 and later, LOCE 2002 and LOE 2006
- Organic Law on Legal Protection of Minors, of 1996
- Law on Cohesion and Quality of the National Health System, of 2003
- National plans of Child and Adolescent Care
- Law on Child and Adolescent Care Councils, 1999.

## **2.3. Areas of Action**

The areas responsible for early childhood intervention are basically: *health, social services and education*, and fulfilment of the objectives of early childhood intervention requires organised collaboration among the ministries for each of these areas because all of them have responsibilities during childhood. Each of

these has the necessary organisation structure to attend to the child population in their own areas of responsibility, and they have the professionals and suitable action and management mechanisms to achieve their aims.

### **2.3.1 Healthcare Area**

Early childhood intervention (ECI) came into being in response to a reduction in the infant mortality rate and increased morbidity. The healthcare services have responsibility for the prevention of diseases and deficiencies, maternal and infant primary healthcare, early detection, paediatric and rehabilitation treatments, as well as over the primary healthcare teams. Activity is initiated in the rehabilitation, paediatric, neurology and maternity services, which promotes intervention in children with established illnesses and those considered to be 'high risk'.

This model enables a good connection with detection services (neonatology and paediatric, rehabilitation, etc.), and clinical and organic diagnosis of the child, although it causes difficulties in the detection, diagnosis and treatment of problems with a social origin. The theoretical focus of ECI is based on pathology and the action is fundamentally therapeutic.

The General Law on Healthcare, of 1986, establishes as healthcare actions '*programmes for care of high-risk groups*' (Article 18.5). Royal Decree 63/1995, of 20 January, regulating the healthcare provisions of the national health system (BOE [Official State Bulletin] of 10 February) envisages the healthy child programme on a primary healthcare level, and on a specialised healthcare level, the neonatal examination and the application of the treatments or therapeutic procedures as required by the child, as well as rehabilitation (Alonso Seco, 1997).

The different services (obstetrics, neonatology, paediatric neurology, developmental monitoring units, primary healthcare), as well as the programmes guided by protocols for children at risk in developmental monitoring units that were established in Spain after 1978 by the National Plan for the Prevention of Mental Retardation, aimed at children at neurological/psychological/sensory risk or with already established central nervous system damage, have enabled the early detection and timely treatment of developmental anomalies (Zamarriego & Arizcun, 1981).

The introduction of the 'Healthy Child Programme' involved important preventative work and the detection of warning signs and developmental



disabilities. The paediatrician trains and advises the family on the prevention of sleep disorders and on feeding, hygiene, etc.

**The paediatric neurology service** is another of the services that have traditionally carried out early childhood intervention programmes in coordination with the neonatology service to detect, diagnose, care for and monitor children with disorders or those at high risk. The paediatric neurologist is responsible for performing diagnoses of the function, syndrome and aetiology of developmental disorders in children, especially in processes with an organic basis.

**The child rehabilitation services** are another of the groups of professionals that have initiated ECI activity, caring for people who have presented some kind of deficiency. Their work is also closely tied to the movement of associations for early childhood intervention, and they provide specialised treatment of different pathologies.

**The child-adolescent mental health services** have been recently incorporated and participate with preventative childhood health measures, performing interventions in mental health units with individuals or groups, or with the family.

### ***2.3.2 Social Services Area***

**INSERSO (National Institute of Social Services now IMSERSO)** is the service with the most involvement in this area in Spain. The work began in Madrid and Barcelona. In the beginning, the aim was to develop and strengthen the areas where a child had difficulties, considering motor development as the basis for actions, as well as the cognitive aspects, language and personal autonomy. In 1979, the Ministry of Employment through the SEREM (Service for Rehabilitation of the Disabled) created nine pilot early childhood intervention services in the social care centres of various provinces. With the enactment of the Law for Social Integration of People with Disabilities (LISMI, 1982), early childhood intervention units were integrated into the social care centres, which contributed to the generalisation and consolidation of early stimulation in the social care centres of various provinces. After 1980, they began to operate on a regular basis.

The social services carry out many types of early childhood intervention actions such as:

- **Programmes to promote family wellbeing**

- **Prevention programmes aimed at contexts ‘with social risk or difficulty’**
- **Intervention programmes in centres** (social intervention by the early childhood intervention teams).

**The following resources are available:**

- a. Social Care Centres:** The social care centres are where the early intervention activity began. They originated with the Ministry of Labour, which made the INSERSO responsible for starting up ECI. In March 1980 the first eight early childhood intervention services were created as part of the Spanish social care centres. The teams at the social care centres have played a very important role in the promotion of ECI. In general, these have become part of the ECI networks of the different autonomous communities. The INSERSO defined them as ‘specialised social services for basic care of people with a disability that inform, diagnose, evaluate and intervene therapeutically’ with early childhood intervention services maintained as part of the social care centres
- b. Early Childhood Intervention Centres (ECIC):** These began in the 1970s, within movements involving associations of parents and professionals, and they have progressed to become independent specialised centres with positions that are subsidised or contracted by public institutions. These can be considered the driving force of early childhood intervention, at least in Spain, and they have evolved constantly. They are part of social services and work in collaboration with the social care centres. They also have an interdisciplinary team. They receive the family, perform interviews to determine the family situation and assess the level of the child’s development, and prepare an individual care programme for the intervention, with periodic reports to the parents. They carry out the work of providing care/therapeutic intervention (tertiary prevention) in the child population from 0 to 6 years of age with developmental disorders or at risk for them. Currently, they support this activity and care for the children from 0 to 6 years who have been assessed as having a disability of at least 33%. They work in different areas of *direct care*, which are

Intervention unit: social worker, psychologist, and educator.

Therapeutic unit: clinical psychologist, physiotherapist, occupational therapist, stimulation therapist, and psychomotor therapist.

The procedure for action is sequential: study of the problem, preparation of a diagnostic opinion that serves as the base for the preparation of an intervention plan, monitoring of the action plan, and end of care because of discharge or referral.

The main objectives are detection and assessment (they do not have diagnostic authority) of developmental disorders so that therapeutic intervention can be initiated, and family support and counselling, when the first signs of developmental problems appear or when situations that may cause them are detected

c. Early Childhood Intervention and Child Development Centres (CDIAT in its Spanish acronym): These are interdisciplinary services aimed at the child population between 0 and 6 years old. They must work on aspects related to child development in a holistic way. Their main function is to strengthen the abilities of the child as far as possible so as to achieve family, school and social adaptation. The CDIAT's professional team must be interdisciplinary and made up of professionals with a holistic orientation, considering that the intervention will cover intrapersonal, biological, educational, psychological and social aspects for each individual, and interpersonal aspects, related to their environment, such as the family, school and culture (GAT, 2000: 38). The CDIAT must not belong to a specific sector (health, education or social services), and it must be located in a particular region and town where it offers its services. Coordination is a fundamental element in the activity of the CDIATs. These centres are a proposal for an early childhood intervention service put forward by the GAT (Early Intervention Group), but nonexistent in reality. Centres with models close to this proposal exist only in some autonomous communities (such as Catalonia), but as a parallel service to health or education services. Child Development and Early Intervention Centres (CDIAT).

### ***2.3.3 Education Area***

The education administration assumes its responsibilities for early intervention in nursery and preschools (school support of children with special education needs) and through its support services (early intervention teams). With the enactment of the LISMI, early intervention achieved legislative support, and Royal Decree 334/1985, regulating Special Education, provides for early intervention to be provided or funded. Special education is given from the

moment that it is considered necessary, at any age, or if there is a risk that deficiencies might appear (Real Decreto 334, 1985).

The LOGSE (1990) and the Law on Education (2006) recognise the right to educational attention from the moment of birth. The education services perform actions to support the child and the family through nursery and preschools (0-3 years and 3-6 years). The work of these schools is to prevent developmental disorders, which is fundamental for high-risk populations, as they offer a stable, stimulating and normalized environment to the child population that may suffer in inadequate situations in the family environment.

Teachers and educators become detection agents, because at this stage they can observe problems in the different developmental areas of motor skills, socialisation, language, attention, cognition and emotions that have not yet been detected.

Providing this information to parents, professionals and services in the network of existing support in nursery and preschools (support teacher, speech therapists, physiotherapists, educational guidance and educational psychology teams, early intervention teams) enables coordinated action, as well as referral to the corresponding services (paediatrics, early intervention team, early intervention centre) to establish the most suitable intervention. The early intervention teams are responsible for preparing the 'Statement of Special Educational Needs' to assess, coordinate, supervise and establish the child's special educational needs.

They offer a qualified service with an interdisciplinary perspective that can approach the holistic development of the child without losing sight of the specialist role of each of the professionals that will care for him or her. They determine the educational needs of children between the ages of 0 and 6 years, finding and referring those that present differences from the norm at their age, and they contribute to the preparation of the curriculum for this stage, providing technical support for the integration programme for children in the 0-6 age group. They work with nursery and infant school professionals in the preparation of programmes and in the setting of the most appropriate objectives, materials and procedures in the teaching-learning process, as a function of shared criteria, thus avoiding parallel treatments of each aspect of child development.

They also work at preferential integration centres, which are mainstream

nursery and preschools where children with a specific type of disability (hearing, motor, visual, etc.) are integrated, or special education schools where these children receive the attention they need from specialised personnel.

The following table summarises the ECI actions that are carried out in each of the services:

Table 1: Summary of ECI actions

SERVICES	DETECTION (who)	ASSESSMENT	INTERVENTION AND MONITORING
<b>EDUCATION</b>	Educational psychologist, doctor, physiotherapist, speech therapist, educational therapist, learning and language teacher, special education teacher and social worker	Educational psychology, functional, statement of special educational needs.	Direct and indirect, family, school (mainstream integration or support and specialised centre), stimulation
<b>HEALTH</b>	Doctor (rehabilitation specialist, psychiatrist, paediatric neurologist and others), psychologist, physiotherapist, speech therapist and social worker	Medical, functional	Primary healthcare centre, direct and indirect
<b>SOCIAL</b>	Social care centre: educational psychologist, doctor, physiotherapist, speech therapist and social worker	Educational psychology, social-environmental care, family, disability assessment	Primary healthcare centre, direct and indirect (clinic), stimulation
	CDIAT: psychologist, educator, stimulation therapist	On demand, psychology, social-environmental care, family	

(Gútiérrez 2005:36)

## 2.4 System of Access (Eligibility) for Early Intervention Services

There are various different access paths to early intervention services:

- A) The social care centres are agencies of social services. The work they perform is: detect the child, receive the child and his or her family, assess the needs, perform the diagnosis (which may be related to aetiology, syndrome or functioning), and provide orientation and indicate treatment (Gútiérrez,

2005). They have a team made up of professionals of different disciplines who are responsible for detecting the child, receiving the family, assessing and diagnosing the child, and providing orientation and treatment. They are responsible for assessing the degree of disability (33%) that enables access to the Early Intervention Service. The medical and psychological early intervention/early stimulation treatments aim to avoid the degenerative process of a disability and to strengthen the development of the physical, psychological or sensory development of the affected person. To qualify for a place in the programme (funding) the requirements are:

- age 0 to 6 years
- preparation of the intervention programme
- proof that other services are not received.

B) In the educational environment, if the child is in school, then the Early Intervention Teams are responsible for assessing, coordinating, supervising and facilitating the process that enables children with special needs to attend nursery and preschool, while supporting the integration process. They assess the child and prepare the Statement of Special Educational Needs and Early Intervention Needs.

## **2.5 Professionals Involved**

It is important to note the variety of professionals, with different training and profiles, who are involved in the processes of early intervention. In general they are professionals from the fields of medicine, education, psychology and social work. Since their establishment, the ECI teams have had a psychologist, educator, rehabilitation doctor, social worker, early intervention worker and, depending on the needs of the population they serve, speech therapist, psychomotor therapist, and physiotherapist. The theoretical focus of this model is to achieve holistic and continuous care of the child, who requires an enriching family environment.

## **2.6 Children Targeted for Early Intervention**

Children who may receive ECI are all children between birth and age six who present any type of deficiency and those included in the group of high biological and social risk, described below. These children would be included in the following groups:

- A) Children at high biological risk.** This group would include children born premature; with low birth weight; coming from neonatal intensive care; who suffered asphyxia; with warning signs, etc. (Guralnick & Bennett, 1987). Inclusion in this group is determined by the existence of certain biological risk factors.
- B) Children at social-environmental risk.** These are children who come from economically disadvantaged environments; with low socio-economic status; whose father/mother is absent; who were abandoned; or whose mother is an adolescent or suffers from mental health problems.
- C) Children with documented difficulties or disabilities.** This group includes children with documented delays, difficulties or disabilities, which may be cognitive, sensory or related to mobility or communication. For these children, ECI programmes are not just necessary but a right that cannot be waived. This involves intervention from the time of birth or whenever the deficiency is detected.

## 2.7 Parental Participation

Once the effectiveness of the early intervention programs was shown, the parents of the affected children decided to seek information and organise themselves so that their children could receive appropriate treatment. These initiatives led to institutional funding for the creation of stimulation centres and individual grants, which appeared for the first time in the Action Plan 1977 for Recovery of People with Psychological Disabilities of the SEREM (following Alonso Seco 1997).

Attention to parents is considered essential, because they are the most important people in the development of their child and potentially the most efficient stimulation comes from them. They are offered training and supervision in the care and upbringing of their child, psychological development, and psychological support to reinforce their self-esteem and confidence. Their participation is not too 'active', because of the way the system works and the fact that parents do not traditionally play a key role in work with children. They are limited to accepting guidelines provided by the professional team that is caring for the child.

## 2.8 System Funding

In 1980, the INSERSO (National Institute of Social Services, now IMSERSO) officially initiated early intervention 'as specific treatments provided to children who from birth or in the first years of life have been affected by a deficiency

or are at high risk of suffering from one'. Since 1977 private initiatives have received funding for the creation of early intervention centres and between 1980 and 1985, the majority of the centres existing today were created. Health, education and social services have been responsible for early intervention services, with funding and social security benefits.

Each autonomous community assigns the management of public resources for early intervention, which is the responsibility of different areas (health, education or social services). Through different laws, the different public administrations assume the commitment to intervene in the prevention and treatment of disabilities, and the complete rehabilitation and integration of people with disabilities into society. The amounts allocated in the budgets of the different ministries vary from one autonomous community to another. One of the best examples of a consolidated network, of infrastructures and resource assignment, is the Catalan network.

## **2.9 Organisation of Early Intervention**

In practice, early intervention is a process in which each service (health, social and education) must invariably participate and collaborate in the interests of the best overall care for the child.

### Treatments

Since the beginning of early intervention, reference has been made to treatments.

The techniques that may be applied in early stimulation are

partly rehabilitation and partly educational psychology. The aim is to address the full complexity of the subject, working in five main areas:

- psychomotor skills
- cognitive development
- emotional and social development
- language therapy
- physiotherapy and orthopaedic medicine.'

This intervention includes different techniques and therapies appropriate to each specific deficiency and include

- information and detection



- diagnosis and orientation
- educational psychology and rehabilitation treatments
- support and counselling for parents
- technical assistance and support of preschools with ‘children at risk’ attending.

These type of centres offer sessions, usually in the centre and occasionally in the home, at different intervals (45 minutes, twice per week on average) and they also perform periodic reviews.

### **3. Concept of Early Intervention**

Early stimulation, or early childhood intervention or stimulation and now, early intervention are different terms used to describe actions that, of a preventative nature and with an educational focus, aim to avoid or mitigate difficulties in children with clear deficiencies or those who are included in groups considered to be ‘high risk’.

Currently, and as a consequence of these activities and the agreements made by professionals of the early intervention group belonging to different environments and Spanish autonomous communities, we have the agreed definition resulting from the preparation of the ‘White Paper on Early Intervention’ (GAT, 2000).

This model has some clearly differentiated characteristics:

- The child is the principal agent of his or her own development
- Change to the educational model
- Care is linked to the first diagnostic assessment
- Key role of the family
- Natural environments with significant activities
- Importance of support by a team of professionals.

‘Early intervention is understood as the set of interventions directed at the population of children from birth to six years, the family and the environment that aim to respond as soon as possible to temporary or permanent needs of children with or at risk of suffering developmental disorders. These interventions, which must consider the child holistically, must be planned by

an interdisciplinary and transdisciplinary team of professionals.’  
(GAT, 2000: 13.)

#### **4. Assessment of the Current Situation from the Professional Point of View Considering the European Perspective**

The basic principles that are considered essential to be able to speak of a quality model of early intervention for early childhood are far from being fulfilled in Spain. We will now list various aspects that we believe need improvement.

1. It is necessary to create and develop legal regulations that guarantee the achievement of ECI services throughout Spain. This means guaranteeing the provision of the service, given that it is not offered to the whole population in need, and there are large differences in access to early intervention depending on the place of birth, autonomous community, political models and distribution of resources in each of these, which is currently provoking discrimination against some children.
2. It is necessary to coordinate early intervention among institutions. The different ECI services must be coordinated (exchange of information, records and referral protocols). This coordination is essential to achieve optimal use of the human and financial resources of each administration and to respond appropriately to the children’s care needs. This must apply to both the professional sectors affected and the local, regional or national institutions that have responsibilities in this area. The problems do not originate so much in a lack of resources as in the fact that the use of the resources is not coordinated and complementary.
3. Family participation is still a challenge that needs to be addressed. Parents are still largely spectators and occasional collaborators in some activities. Although there has been a clear improvement in the collaboration of all the parties involved in the process (that is, the family, professionals and society), a model of early intervention in which they fully participate has still not been achieved.
4. Standardise the Health, Education and Social Services information systems, standardising recording and referral protocols. Establishing uniform data collection about disabilities in all of the organisations involved enables more

information to be gathered about the population in care and the work carried out, enabling real needs to be detected and appropriate resources assigned. The use of studied classification criteria, in areas as fundamental as coding, makes it easier for different professionals to work together effectively.

5. The interdisciplinary character, professional qualification, functions, responsibilities and areas of action of the professionals who work in this field have continued to grow in health and social institutions and education teams and early intervention centres. They are well qualified, but receive little social or financial recognition.

In spite of the fact that freely, universally and equally available opportunities are an objective that is far from being achieved, the process of social, political and administrative recognition has already begun. Professionals who work in this environment are beginning to contribute to a common doctrine, to share criteria, uniting different medical, educational and psychological cultures and enabling the development of a common system that favours early intervention activity and that will benefit the achievement of the full development of the child and improve his or her quality of life.

In conclusion, and in spite of the above-mentioned difficulties, this document has described the appearance of a young discipline, of a field of action to manage disability and vulnerable populations that is active and continually changing, which must be consolidated to enable a quality and comprehensive response to the needs of early childhood. And this process is already underway.

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# Early Childhood Intervention in Turkey

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## 1. Families in need of support: “Kayra”

*I was asked to write about how I felt when Kayra was diagnosed for the first time. Actually, somebody asked me whether I would like to write about it. I said I would. Why should not I! If what I am going to write about going to benefit other children and mothers, why shouldn't I write? Since there are not many mothers writing about, maybe I will also contribute to those who struggle with autism...*

*Actually six years ago, there was nothing like a diagnosis for autism. There was no diagnosis, no treatment, and no consultation. You are all alone with all the questions who want to ask, until you find someone like you. Therefore, like many other mothers, I tried to proceed on my own. No one told me what to do. I searched all possible ways on my own slowly, trying to find a way for myself and my little boy. What I did was like digging a hole with a needle. That was the reason why I was struggling to find a doctor who would tell me what was the matter with my child and what I should do in every hospital in Ankara, at Hacettepe University, or at Gazi University, with my 1.5 year old boy. I was looking for a cure. Therefore, I did not have a stage of acceptance. I knew that the time was so valuable that none should be lost and I was in a race where second matter. That was exactly what I told the doctors, too. I pleaded them to tell me what the matter was and more importantly, what I could do. Of course nobody told me the matter before a year. Every time I went, the doctors would tell me to play lots and lots of games with the boy, take extreme care of the child, and come back a month later. They would not tell me how I should play with the child. In fact, games are not simple things at all. Games are vital for autistic children. I did whatever they told me. I played and took extreme care continuously; however, it took a year for the doctors to decide that the child needs training. They wanted to make sure that the diagnosis was*

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*definite! Furthermore, there was no extensive training, at least one that I knew of, at those times in Turkey. No one told me, either. As it is also done today, all our children were scheduled with an one and a half hours of training every month. I found out all by myself that the child needs individual, intensive training of high quality and that training is vital for the child. Of course, the search and realizing all this took me another two and a half years. It took me another year to find the intensive training. To make things short, we always lost time. In fact, I had taken a child with autism for diagnosis at the earliest age possible... And I had done everything they told me in the best way I could.*

*I did not want to lose time crying in the process. I cried out loud when Kayra was asleep. As I saw time was precious. I wouldn't be able to take care of him, if I cried all the time. Besides, I didn't want him to see me crying. While he was asleep, I ran to the nearest internet café for research. I called every mother I could while he was asleep. I cried when he was sleeping. I did all these in order not to waste any of his time...*

*At those times I feared the most that when he wakes up, he would not recognize me. I knew so little about autism that I thought one day when he wakes up, he would not recognize me. He would not recognize me or anything else...*

*The first three years of the struggle, I did all by myself. I was both alone and there was pressure, too. My husband, his family and others did not accept the case. They accused me of making a bad name for the child, for labeling my boy as an autistic.*

*I am not offended. I forgave them. They were who they were, and I was who I was.*

*Little Kayra, who could barely sit, attended a nursery school that was ready to accept us during this period. All these were done so that Kayra could see his peers and spend some time with them. Every day I put him inside his trolley and went to the other end of Ankara, even in rainy days and snowy days. We climbed up a road for half hour, a road that was 70 degrees in inclination angle. It was difficult to climb up that road, but the way down was fun. Because we had to go down fast, Kayra was so happy. He would laugh loud as we went down, I would, too.*

*Every day and night, Kayra and I were alone. When he slept during day time, I would sometimes lay next to him. I would shut my eyes and pray. I would pray "Oh Allah, please, let Kayra not be an autistic anymore. I was so afraid of autism at those times. What I read from the internet would say, autistics cannot recognize anyone, they cannot differentiate objects from humans, they see humans like objects, they will not attach with spiritual bondage.*

*You cannot defeat autism actually, because it is so strong. Never listen to mothers who make public announcements like I worked so hard for three months and I cured autism. If the brain is damaged, if the five senses are damaged, namely if the child is really autistics, you may not proceed a little even in three years, leave a side three months. However, if you stand against it strongly, you stop the disorder from getting more severe. You may even reverse the process and make progress in the child's development. As autism step back, you step forward... You move step by step.*

*Now I have a child who loves human beings so much. A child who laughs out loud and plays hide and seek with me. Even if it is with some extra support, my child goes to the same school his peers go to. He rides a bike, he swims, he skateboards, and above anything else my boy can speak. I try to teach him everything I know. Yesterday, I showed him how to climb up a tree and how to stand up on a swing, as well as swinging on his own.*

*I believe that every kind of struggle pays off, even though the results may not be apparent immediately. I would do it even if it had no benefit. Would you have done the same! Every mother will do the same, anyone who is a mother or a father would do the same. Anyone who is humane...All living beings...*

## **2. Introduction**

The early years of the human-being are the foundation of his/her future. Many professionals from diverse but interrelated fields such as psychologists, educators, speech and language therapists, and others have recently been recognizing the critical importance of early years. Therefore, they have been also recently paying great attention to providing early education or intervention not only to children with normal development but also to children with special needs or those who are at-risk to show special needs. Young children with special needs are in need of immediate intervention or show diverse intervention or education needs because of their mental, physical, behavioral, developmental, or learning characteristics.

Young children with special needs can be described under two categories: children who have identified disabilities and children who are at-risk (Blasco, 2001; Dunlap, 1997; Hooper & Umansky, 2004; Howard et al., 2005; Peterson, 1987). The first category includes young children who have identified disabilities, such as cognitive, physical, behavioral, language, or learning disabilities based



on the eligibility requirements of the special education law mandated. The second category comprises of young children who have not yet identified, but show at-risk characteristics to be identified. These young children can be described under three headings (Peterson, 1987):

(1) *Young children who are environmentally at-risk.* The environment in which young children grow and develop can put them under critical risk conditions that influence the development of young children negatively and that may end up with academic and social failure in the future. These conditions have been identified as economic and social factors of persistent poverty, high levels of child abuse, substance abuse, disintegrating families, inadequate health care, and very poor child care.,

(2) *Young children who are biologically at-risk.* Some biological characteristics of young children may result in disabilities or school failure. The most common known conditions are premature birth or low birth weight, and

(3) *Young children who have established risk conditions.* Some young children are born with established risk conditions such as chromosomal disorders, inborn errors of metabolism, congenital malformations, sensory loss, and injuries which most likely result in significant developmental differences.

Early intervention, early childhood intervention, early childhood special education, preschool special education, early special intervention are some of the common terms that are used by different professionals to describe the special services provided to young children with special needs or those who are at-risk for special needs and to their families. In this article, the term early childhood intervention (ECI) will be preferred to describe special education services provided to young children-birth to age 6- with special needs or those at-risk for special needs and to their families in Turkey. Professionals at European Agency for Development in Special Needs Education (2005) define ECI as

a composite of services/provision for very young children and their families, provided at their request at a certain time in a child's life, covering any action undertaken when a child needs special support to: ensure and enhance her/his personal development, strengthen the family's own competences, and promote the social inclusion of the family and the child. These actions are to be provided in the child's natural setting, preferably at a local level, with a family-oriented and multi-dimensional teamwork approach (p17).

Within the scope of this article, the ECI can be defined as “providing necessary various services such as health, nutrition, and education based on the needs of the child and his/her family in order to minimize the negative effects of the situation influencing the child and his/her family and to maximize the overall quality of life of the child and his/her family.

The purpose of this article is to overview ECI services regarding young children -from birth to age 6- with special needs or those who are at-risk of showing special needs and their families in Turkey. For this purpose regular early childhood education system are being briefly covered. Then, profile of disability groups, legal arrangements (within the scope of education) and practices in ECI, ECI profession, and finally suggestions are being be addressed.

### **3. Regular Early Childhood Education in Turkey**

Early childhood education services in Turkey are carried out by Ministry of National Education (MNE), Republic of Turkey Prime Ministry Social Services and Child Welfare (SHÇEK) and non-governmental or other private/state institutions, which are in corporation with these two governmental organizations.

Early childhood practices in Turkey lead back to really old dates. Childhood education is a historic process that extends from late 19<sup>th</sup> century into early 20<sup>th</sup> century to the modern days, starting in the Ottoman with some legal arrangements and expands in the modern state, yet the end of 1960s appears to be the date when early childhood gained importance and number of institutions soared up remarkably (Haktanır et al., 2010). According to the 2010 statistics of Ministry of National Education, the schooling rates of children at the age of 36-72 months per years presented in every ten years from 1980 to the data are as below: in 1980-1981 1.9%, in 1990-1991 5.1%, in 2000-2001 10.3%, in 2004-2005 16.1% and in 2009-2010 39%. As it can also be seen in Table 1 which is derived from the 2010 data of Turkey Statistics Institutions and Ministry of Education, the early education schooling rate increases with reference to age. Schooling rate for 60-72 months old is almost 15 times more than the schooling rte for 36-48 months. There is no data for infants and toddlers at the age of 0-36 months (Haktanır et al., 2010).

Table 1: 2009-2010 Academic Year Distribution of Schooling Rate with Reference to Age groups\*

<i>Age group</i>	<i>Number of Students</i>	<i>The overall population at that age group</i>	<i>Schooling Rate %</i>
<b>36-48 Months</b>	50.804	1.219.479	4.17
<b>48-60 Months</b>	201.033	1.200.634	16.74
<b>60-72 Months</b>	728.817	1.194.493	61.01

\*Reference: (Haktanır, Dağlıoğlu and Güler, 2010)

It is possible to talk about two education models in the early childhood education, namely institution-based and home-based models (Haktanır et al., 2010). Institution based educational models, which are early childhood service practices that are carried out in institutions; functions under the Ministry of Education and Republic of Turkey Social Services and Child Welfare Foundation. Hence, there are institutions affiliated to different directorates within MBE and there are institutions affiliated with Republic of Turkey Social Services and Child Welfare Foundation. Institutions affiliated to MNE are Independent Nursery Schools serving children at the ages of 3-6, Private or State Nursery Classes within General Education schools serving children at ages 5-6 supervised by the General Directorate of Pre-Primary Education, and Practice Nursery Schools and Nursery Classes and Private Nursery Schools serving children at the ages 3-6 supervised by General Directorate of Technical Education for Girls (Haktanır et al., 2010).

Services for early childhood education under Republic of Turkey Social Services and Child Welfare Foundation also serve for children under three years old. Within this foundation, there is “Crèche-a kind of daycare center” for children below three years old, Daycare Centers for children at the ages of 3-6 and Children Nursery School for all children at the ages of 0-12. Crèche and Daycare Centers are social services institutions that provide services for a fee and are non-boarding. These two institutions can be founded as one body, or can serve as two independent bodies. Children Nursery Schools can serve all children from birth until 12 years old, and in some cases, can serve girls who are older than 12, too. These are boarding social service institutions that are responsible for and obliged to taking care of children who are in need of protection. Besides, there are also nursery schools affiliated to state/private

institutions and foundations (e.g. universities, Turkish Radio and Television, Mechanical and Chemical Industry Corporation and banks). Home based education programs are carried out in cooperation of non-governmental organizations or governmental organizations and MNE targeting the mothers. Among the most known examples of home based education programs are: Mother-Child Training Programs (AÇEP) targeting mothers of children who are at risk socio-economically and cannot attend nursery school; Mother-Child Training Programs targeting mothers of children at the ages of 0-6; and Mother-Father-Child Training Projects targeting young ladies, prospect mothers and other women and men, aiming to raise children (Haktanır et al., 2010).

#### **4. Profile of Disability in Turkey**

Profile of disability in Turkey was comprehensively researched by means of “Turkey Disability Survey” which was implemented in 2002 by Turkish Statistical Institute upon the demand of Prime Ministry of Turkish Republic/ Presidency of Administration for Disabled People. The survey results indicate that the number of persons with disabilities in total population is in the ratio of 12.9%. This means there are 8.431.937 individuals leading their lives with different forms of disabilities. Disability is regarded as an issue affecting not only individual with disability personally, but also his/her family and peers in economical, social and psychological aspects.

In accordance with the statistical data of “Turkey Disability Survey”; in the age group of “0 – 9”, which includes early childhood, children with any one of orthopedic, visual, hearing, speech, language or intellectual disabilities have the rate of 1.54%, while children with chronic illnesses in the same group have a higher ratio of 2.60%. This means that approximately 4.14% (2,8 million) of population in the age group of 0 – 9 needs special education. The data also indicates that about 12.27% of population with disabilities (approximately 8.431.937) receives educational services, while 87.73% can not. The fact that there are 2.8 million children with the need of special education in the age group of 0-9 covering early childhood necessitates the provision of educational needs of this group as accurate as possible and underlines the importance and the urgency of special education in early childhood.

## 5. ECI Legal Arrangements and Practices in Turkey

In Turkey, from an educational perspective, special education early education services are carried out through legal arrangements. In this sense, in the decree having force of Law numbered 573 issued in 1997, “it is essential to start special education early” comes under the Basic Principles of Special Education (as per article 4, b). Furthermore, MNE Special Education Services Legislation, which was issued first in 2000 and revised in 2009 presents detailed information regarding special education practices and early special education services are planned and carried out according to the legislation. The diagnosis principles in the legislation that cover early education (Statement 10, a paragraph) are related to “earliness principle” and it is stated that “diagnosis should be made as early as possible”. Although there is a principle about it in the legislation, it can easily be seen that in our country, there is no screening and diagnosis system. Therefore, finding children and families in need of special education needs in the early period is done by chance. Similarly, families need to initiate the process or be fortunate enough to be noticed early so that they can receive the necessary early intervention. Many families, if they are not aware of the delays in their child’s development, enter the diagnosis system when their children start formal education. Lack of early screening and diagnosis tools is another important issue, maybe as serious as lack of early screening and diagnosis system.

It is also emphasized in the same legislation that in Turkey, special education services should be planned and conducted by Guidance and Research Centers (GRC) affiliated to the Ministry of Education and founded in every provincial and district directorates for national education. With reference to that, the educational assessment, diagnosis, placement and monitoring services for individuals with special education needs are carried out at GRC centers. At GRC’s, the educational assessment and diagnosis are conducted by a special education assessment council constituted with the GRC, using objective and standard tests and measurement tools that are appropriate to the individual’s attributes. “In the diagnosis; the individual’s medical board report, mental, physical, psychological and social development characteristics, academic discipline area competencies, educational performance, the need, the duration of service provision and individual development report are taken into account. (Statement 7:2). Special education services board will place the individual in a suitable state school or institution based on the special education assessment

board report. Concordantly, GRCs lack screening and assessment tools especially at 0-6 ages; the tools available are not up-to-date; and the personnel working at GRCs hasn't received any training about these assessment tools. All these lead to serious doubts about the reliability of screening and diagnosis processes of GRCs (Bozkurt, 2009). Even if the child makes use of the early diagnosis services, despite all the problems presented above, providing suitable educational contexts for that child and his/her unique attributes is another source of problem. According to the 2009-2010 statistics of MNE Special Education Guidance and Research Center General Directorate, there are four Early Childhood Education Center Nursery School and only one Early Childhood and Pre-school Education Center. There is no data about the number of students and personnel in these institutions.

In the related legislation, education services are regulated under specific titles. With reference to this, there are regulations under the title of special education services in the early childhood period of 0-36 months. In this regulation, it is emphasized that early childhood education includes the education of individuals who are at 0-36 months of age and that the following issues should be taken into account in the education service practices:

- a) early childhood educational services are planned in such a way that the education during this period helps to arrive at the expected learning outcomes at later stages of education.
- b) early childhood education is carried out to contribute to individual's education and in order to contribute to that individual's education, the families are informed and supported,
- c) early childhood education services is carried out at schools or at institutions, as well as at home if there is a need.
- d) the planning and coordination of early childhood education services are done by the special education services council. The necessary regulations are made and the necessary measures are taken so that individuals with disabilities receive education with their peers without any disabilities or the individuals with disabilities receive these education services in independent units that are to be established.
- e) in order to plan and carry out early childhood education first the needs of the individual and his/her family are identified.
- f) the ministry cooperates with affiliated institutions and organizations in the screening and diagnosis of the individuals, as well as in the provision of

education services.” In the same legislation, there are regulations under the title “special education services in the preschool period” for children with special needs at the age of 37-72 months. According to that, it is stated that “(1) for individuals with special needs at the age of 37-72 months, pre-school education is obligatory. However, considering the individuals’ developmental and individual attributes, the pre-school education period can be extended for a year, (2) the pre-school education of those individuals who are in need of special education should be carried primarily within the scope of inclusion practices; however, for these individuals, there could also be special education classes or pre-school private school / institution”. In the related legislation, under the title of “educational services at home”, it is also stated that those individuals at pre-school period who are in need of special education, but cannot benefit from education-training institutions directly should receive the necessary education at home. “Family education” is defined as “education that includes all sorts of guidance and counseling given to the family, in order to contribute to the individual’s education at all levels of education”.

Although there are important statements in Special Education Services Legislation, in practice, it is observed that neither what is stated in the legislation are really practiced nor are the necessary steps taken to put these in practice. The lack of system observed in the screening and diagnosis processes are also observed in the educational processes. It is stated that especially the education in the infant and toddler periods will be carried out in institutions or at home, but there is no systematic practices to provide services at this period. The children who are diagnosed or noticed are left behind during this period. The education of children between 0 – 6 who show meaningful developmental delays or some deficiencies (compared to their peer group) is offered by either an increasing number of “private rehabilitation and special education centers/schools” or “public regular schools or public special education schools/institutions”.

## **5. ECI Profession in Turkey**

Regarding ECI, there are no qualification standards for ECI professionals. Actually, there is currently no formal position named as ECI Professional or Early Interventionist in Turkey. The services oriented to children and their families are performed by special education teachers graduated from one of the departments of special education for children with visual, hearing or mental disabilities, or professionals from related fields such as child

development, special education, regular early childhood r, regular elementary school, physiotherapy, psychology, psychological consultation and counseling, etc. Although special education in early childhood necessitates specialized knowledge and skills especially for the education of age group 0 – 6, Turkey has, as stated above, neither bachelor (4-year)/basic training programs nor graduate programs which aim to train qualified professionals in the field of ECI. It is clear that professionals and teachers employed in license and graduate programs on the field of special education in Turkey do not have enough qualitative and quantitative skills to meet the educational, developmental and other needs of children receiving special education and their families.

## 6. Suggestions

The following suggestions can be made for the issues briefly discussed above:

*Early Childhood Intervention Centers (ECICs).* A briefly discussed above, families with young children at-risk or with special needs are in need of appropriate developmental and educational centers in Turkey. Therefore, in working cooperatively with Guidance and Research Centers, Early Childhood Intervention Centers can be started in Family Health Centers affiliated with Ministry of Health, the most common primary health centers can be found in almost every neighborhood all around Turkey. As an alternative it can be established at Guidance and Research Centers also. By establishing the ECICs in Family Health Centers or Guidance and Research Centers, it will be possible to reach out to every single young child with special needs and his/her family.

*Early screening and diagnosis.* There is currently an urgent need to have a “child-find” system in Turkey in order to meet the needs of young children with special needs or at –risk for special needs and their families early. Therefore, establishing a nation-wide early screening and diagnosis system should be considered. In this system, various early screening and diagnosis tools should be adapted or developed and professionals (especially developmental pediatrics or child doctors) who will play role in child-find practices should be trained on using these tools. The system should be part of the ECIC.

*Home and Center-Based ECI practices.* There are currently a few home-based ECI programs [e.g., Small Steps early intervention program (e.g. Batu et al., 2009; Kırcaali-İftar et al., 2001; Sucuoğlu et al., 2000), Portage Early Education Program (e.g. Güven et al., 1998), Behavioral Education Program for Children



with Autism (BEPKA; Kırcaali-İftar et al., 2009), Turkish Version of Responsive Teaching (TV-RT; Karaaslan & Diken, 2009)], in Turkey. Although BEPCA and TV-RT are new pretty new programs for Turkey, Portage is internationally a very-well known ECI program and there are several studies on effectiveness of Small Steps in Turkey, these programs are not part of ECI practices nationwide in Turkey as a national policy. This is may be because of there is no an ECI system and center in Turkey. Therefore, new home-based ECI programs should be adapted or developed and existing programs should be part of the ECICs and provided by professionals who will be positioned in the ECICs. Regarding center-based ECI practices inclusive day care center, playgroups, preschool, and kindergarten practices should be established and provided. Related support services should also be considered while providing these services.

*Training Professionals in ECI.* Professionals graduated from the field of special education or related field and will get training on specifically young children with special needs and ECI services for these children and their families should be positioned in ECICs. Professionals who have been working and will be working in the field of ECI should also get training on the ECI. The best way might be to have graduate (e.g., master) programs in ECI for professionals from related fields such as child development, special education, regular early childhood teacher, physiotherapy, occupational therapy, psychological consultation and counseling, psychology, etc. who have been working in this field for years with young children with developmental delays/disabilities and their parents. Professionals from these interdisciplinary fields have at some level background of the ECI field. If we could provide the info and skills they needed based on their preparation programs, time and money could be saved. As an initiative, Anadolu University have just developed a master program and applied to Higher Education Council of Turkey in March 2010. However, these programs should be widespread in Turkey.

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# Early Childhood Intervention in the UK: Family, Needs, Standards and Challenges

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Wendy Messenger\*\*

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## 1. The UK National Context

A child with complex needs or a disability will come into contact with the appropriate professionals in a variety of ways. Those children whose needs are clearly identifiable at birth will be able to access a range of services from the start and this process, called 'the newborn service', will be initiated by health professionals, normally a paediatrician or midwife. As stated in the Framework for Assessment of Children in Need and their Families (DoH/DoE, 2000: 67), 'The midwife and health visitor are uniquely placed to identify risk factors to a child during pregnancy, birth and the child's early care'. However, for children whose needs are not immediately apparent, there are a number of routes for referral. These include:

- Referral from the health visitor and General Practitioner in consultation with parents and this may be the result of regular checks carried out by the health visitor or concerns raised by the General Practitioner or parent. There does not necessarily have to be a diagnosis at this stage, rather a view that the child *may* have additional needs. General Practitioners are also required to undertake formal checks in which parents are also involved at six weeks after birth where further identification of support of particular needs take place. This would include referral to specialist professional services as appropriate
- In addition, some babies may have been identified 'at risk' even before birth with the family previously known to social services, for example. Such identification immediately generates expert support around the family pre and post birth, with health professionals alerting the appropriate services as required. Any such records, papers and notes are transferred between professionals and this would include the family's General Practitioner who

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at a local level will also have a key role in observing the baby/child as it develops. In turn the General Practitioner has a duty to keep social services informed and updated on any issue causing concern. All health workers have this shared responsibility, both professional and personal, and it is taken very seriously as part of professional medical ethics.

- Some children will come into the prevention and intervention system through referral via a Child Development Centre. There is at least one Child Development Centre in every Local Authority in England and they are funded by the National Health Service. These are for children who may have health needs but may have other needs as well. The children are assessed by a multi-disciplinary team, and with parental involvement an individual programme of support and care is formulated to meet the needs of the child. The assessment team could be made up of any of the following: nursery nurses, nursing staff, clinical psychologist, educational psychologist, teacher, physiotherapist, occupational therapist, speech and language therapist, audiologist, orthoptist, hospital social worker and child development centre co-ordinator
- Others may be referred via a Children's Centre. There is a Children's Centre in almost every neighbourhood in the country (over 3,000) which provides a single point of access where parents can use a variety of services related to health, education and social care. The professionals may be based within the Children's Centre, for example a teacher, family support worker *or* may come to the centre to undertake regular clinics, for example, midwife, *or* professionals within the children's centre can make referrals to other services. Parents themselves can also make referrals.
- Educational settings, for example, pre-schools, nurseries are also responsible for many referrals and systems are in place to facilitate this source of early identification. Within every educational setting there is a 'special needs co-ordinator' who can refer children to the appropriate professionals, for example, speech and language therapist, specialist teacher, occupational therapist, educational or clinical psychologist. Again, this process may identify children across the range of potential needs from educational (learning difficulties, behaviour and emotional difficulties), health (eye sight, hearing or more significant health issues) or social (child abuse, neglect or bed wetting, for example).

## **2. A Family in Need for Support: How this Works in Practice for a Child and his/her Family**

In order to provide a concrete example of how this process may work in practice for the child and the family and how different agencies might be involved, a brief case study is provided. The detail included in this case study was obtained through the process of semi-structured interviews with professionals and families where the same questions were posed and explored and notes were taken by the interviewer. Permission was obtained beforehand for the interview to take place and for notes to be taken. In order that good ethical practice was adhered to, the anonymity of all involved has been maintained throughout and any names have been changed.

### James' story

*Identified at birth through the regular checks undertaken on all new born babies, James was referred immediately for specialist medical intervention. By the age of one year, he had two cochlea ear implants in place and was receiving support from a wide range of services. Apart from the obvious major medical interventions he had undergone, he and his family had from the time of his birth also received support from the local peripatetic hearing support service provided in each regional district (Local Authority) in the UK.*

*This central service allocated a teacher who was trained to work with children with hearing problems and their families. She worked closely with the family in their home environment from the time James was discharged from hospital after birth in order that they would be better able to support the needs of their child. Regular assessments were undertaken in the home by the visiting professional who also supported the family by providing information, education and advice. In addition, she provided centrally produced materials and training for use by the family in her absence which enabled the family to have an active role in monitoring the child's progress as well as empowering them to be part of the assessment team.*

*Linking with the other professionals involved, including health visitors, General practitioner and other specialist auditory experts, and the input right from the beginning of a specialist educationalist, has had a very positive outcome to date for the child and the family. The service for hearing impaired children will continue to have input appropriate throughout James' education both pre-schools and once he is of school age.*

### **3. Accessibility to Support Services**

All such services referred to above are free of charge to the parents/family and are paid for through the UK's national health and taxation systems and provided by the government or Local Authority so are available and free for all who require them. However, though not a key focus of this paper, the impact of a family's own economic circumstances, it has to be stated, have to be taken in to account when professionals undertake child and family assessment. Jack and Gill in Horwath (2010: 379) stress the need to take account of the fact that, 'assessments to safeguard and promote the welfare of children are of limited use unless they are also help to identify ways of improving the lives of economically disadvantaged children and their parents or caregivers'. In addition, they discuss the 'direct and profound impact' of economic disadvantage on the parents' ability 'to meet the needs of their children as well as having direct effects on children's everyday lives and future life chances' (Ibid: 369).

In the UK it is the general policy that parents are involved as partners in a child's care wherever this is possible as it is widely recognised that this model produces the best positive outcomes for children and their families. According to Holland in Horwath (2010: 111), 'Transparency, alongside empathy, reliability, humour and truthfulness, are all traits valued by children, young people, parents and carers engaged in children's services [.....] despite an increasing emphasis on systems and outcomes, relational aspects remain at the core of successful practice with children and families'.

In this particular case study, the parents acknowledged that the inter-agency provision had been beneficial whilst the professionals have achieved a successful initial outcome for the child. This very early intervention from the range of professionals should, hopefully, enable James to make good progress with speech and language and should enable his development to continue to progress satisfactorily in the future.

The services provided for children with additional needs are mostly provided and funded through central government and are free at the point of delivery. Private and voluntary organisations such as the Down's Syndrome Association also exist which provide additional services for children and families and there are many self help groups providing support and advice for parents such as Just Parents, Parenting UK, and PEACH (Parents for the early intervention of autism in children), to name but a few.

## **4. Commitment and Challenges to Early Intervention Services in the UK**

The universal funding of health, social and educational provision in the UK is costly and in the current economic climate, nationally and internationally, it faces challenges for the future. At the time of writing the UK Government, in power since May 2010 as a coalition government, appears, at least through its manifesto, to remain strongly committed to early intervention for children, as was the previous labour government (1997-2010) whose commitment was also strongly evident in practice. (Robertson & Cox, 2008). It is the policies and practices of this latter government which are therefore underpinning current practices outlined in this paper.

Meeting the needs of all children, including those with special needs and more widely vulnerable children, has, particularly since 1997, become much more outcome driven focusing on identification, early action and prevention (Every Child Matters, DfES, 2004) and the Children Act (2004). This has generally meant that in practice a diagnosis or a 'label' may not always be necessary in order for a referral to be made. It may be, however, that a diagnosis or a label could lead to greater funding, resources or more specialised services to be provided for the child where needs are more complex. So for example, a child would need to be diagnosed with complex and severe autistic tendencies in order to be referred for a place in a special education in the school sector, specialising in autism. However, for James, his needs may well be met by the enhanced resources which have been invested in a large number of primary schools which already exist to meet the needs of hearing impaired or children with language difficulties. Thus 'labelling' is avoided when possible and when needs can be met without requiring significant additional resources.

Similarly, the labour government, in power from 1997-2010, had also demonstrated a strongly evidenced commitment to improving the quality of life for children and their families, most particularly vulnerable children. Schemes such as Sure Start were funded and initiated by the government through the Green Paper 'Supporting Families' (Home Office, 1998) to enhance the support for parents to care for their children, whilst other initiatives were introduced to address more effectively issues of child poverty in the UK. 'Every Child Matters' (DfES, 2004) followed by the Children's Act 2004 also had a significant impact on prevention and identifying early concern. We, therefore, wait to see whether

this legacy is maintained and supported in the current changed political and economic environment in the era of a new UK government.

Planning for the delivery in a stringent economic climate will require careful budgeting and a clear understanding of estimated need for the services. However, there appears to be a lack of clear data at both national and local level on the numbers and characteristics of children with additional needs and their use of local service provision. Estimates are between 288,000 and 513,000 children in the UK which equates to between 3 and 5% of children in English Local Authorities. Mooney, Owen and Statham (2008) suggest that most authorities experienced difficulties in providing information on the numbers and characteristics because Social Care, Education and Health differed in their definitions and criteria for categorising disability and additional needs. A report produced by the Centre for Excellence and Outcomes for Children and Young People's services (C4EO, [www.c4eo.org.uk](http://www.c4eo.org.uk)) suggests 'there is a need for greater clarity or agreement of definition of childhood disability across all data collection exercise' (Martin et al, 2009:33).

The 'Every Child Matters' government policy paper published in 2004 advocated fundamental reform of public services to ensure better joint working and information sharing. It suggested there needed to be a whole system reform of the delivery of children's services, founded on the premise that children and families do not distinguish their needs based on which agencies run their services.

Robertson (2009) observed it was necessary for the services to be built around the child and the family, and a shared sense of responsibility across all agencies needed to be developed. Changes in the culture and practice of the workforce and integrated universal services of early years, health and education would become a priority. The change involved several layers of reform, taking a top-down strategic approach, namely:

- Interagency governance of services
- Integrated strategy between services
- Integrated processes between services
- Integrated front-line delivery of services
- Outcomes for children and young people

A national framework for change was developed which put clearly defined outcomes at the heart of the process and gave attention to the following:



policies and products, improvement cycles, how change could be supported, communication, inspection criteria, targets and indicators and outcomes and aims. Fundamentally this was a top down radical approach to improving services for all children including those requiring early intervention. This radical reform of services was later embedded in law in the Children Act 2004.

The range of measures to improve early intervention as part of 'Every Child Matters' included:

- Mechanisms to improve information sharing focused on the development of the Common Assessment Framework (CAF) as a tool which professionals in all agencies could use to indicate they have early concerns about a child and to provide support for the children with additional needs and their families before 'crisis point' was reached.
- The identification of Lead Professionals to co-ordinate support when children are known to more than one service or agency. The Lead Professional would act as a single point of contact and aim to reduce overlap and inconsistency in the services received (DfES, 2004). This role could be taken on by different types of professionals or practitioners within the children's workforce. In addition, the role holder would co-ordinate the delivery of integrated services. Some families may have a key worker instead who brings together a multi-agency team around the child. Whilst the role of the lead professional is mainly co-ordination, the key worker may also provide emotional support, signpost to further information, and time with the family, if necessary.

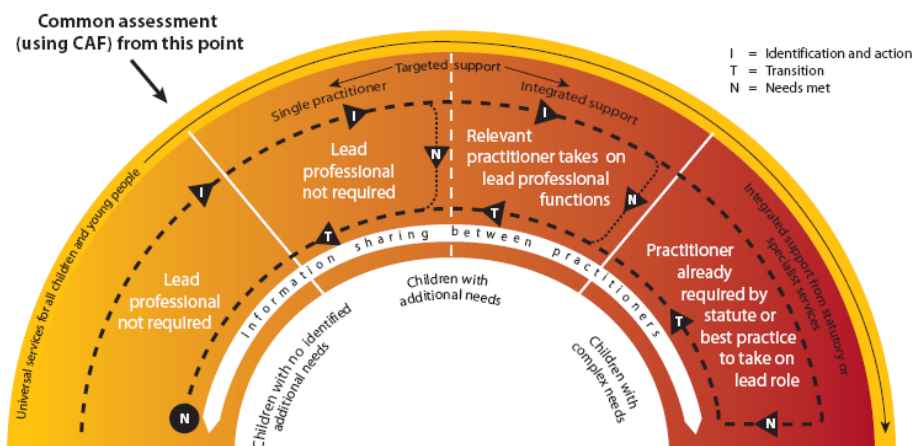
The team around the child may have membership of professionals from health, education and social care as well as the private and voluntary sectors. Limbrick (2007:3) defines this as 'an individualised and evolving team of the few practitioners who see the child and family on a regular basis to provide practical support'.

Each team around the child is individual to the child and the family and aims to meet the needs of parents of babies and young children, empowering them to be fully involved in all decisions and to meet the family's needs for joined up services regardless how many agencies and professionals are involved. For children with complex needs it is possible that a statutory assessment may have taken place in which the provision that is required to meet their needs must be provided in law as outlined in the Education Act 1981.

The following diagram (Figure 1), published by the UK government's Children's

Workforce Development Council (CWDC) in 2007, illustrates the clear continuum of provision which is accepted as appropriate for *all* children in the UK.

**Figure 1: Processes and Tools to support Children and Families (CWDC, 2007:17)**



## 5. The Context of Professional Training in the UK

The term ‘early childhood intervention’ is not a term that is commonly used in the UK, rather it would perhaps be more common for the term ‘early support’ to be used within this context. It would seem the main reason for this is that it is not seen as a discrete discipline in its own right, rather it is part of a holistic approach to meeting the needs of all children that is inclusive of all. It is mainly organised through an integrated approach across a range of professional disciplines. This approach and philosophy has been developed over a number of years and has been the result of government policy, reports and legislation over the last ten years or more, the most significant being ‘Every Child Matters’ (DfES, 2004) referred to previously.

The Early Support programme, funded by the Department for Education, is a partnership between Government and the voluntary sector would appear to be the only training that is a specialist programme in this area. This programme was developed in response to the ‘Together from the Start’ government initiative (DfES, 2002) and takes forward the underlying principles from this guidance, improving the quality, consistency and co-ordination of services for disabled children and their families. It aims to raise expectations about the way agencies and services work, encourage change and provide practical tools to

support multi-agency service development at local level. There is an emphasis upon the development of a 'helping relationship' and empowerment with the child and the family rather than from the perspective of the 'expert model' of intervention (Davis, Day and Bidmead, 2002). Originally focusing on children from birth to three years of age, this range was extended to five years of age in 2007-8 and the initiative was rolled out across England.

Other training can be accessed as part of national vocational qualifications and short courses, delivered through private organizations and government initiatives and prior to degree level. At degree level, training is integrated into a variety of professional courses. Some of these include teacher training and programmes relating to early years professional status, social work, nursing, educational psychology and clinical psychology.

All undergraduate courses related to working with children have to address the common core of skills and knowledge (CWDC, 2010) that is required for the children's workforce that supports integrated working. These include:

- Effective communication and engagement with children, young people and families
- Child and young person development
- Safeguarding and promoting the welfare of the child
- Supporting transitions
- Multi-agency and integrated working
- Information sharing

## **6. Types of Intervention**

Research into improving the well-being of disabled children through early years interventions undertaken by Centre for Excellence for Outcomes for Children and Young People's Services (C4EO, 2009:11) identified that the following interventions, ranked according to their frequency were reported:

1. Family-centred interventions (including Team Around the Child (TAC) initiatives and the Early Support Programme)
2. Portage (a home-visiting educational service)
3. Other home-based intervention programmes such as home therapists and home visits, and the Transactional Intervention Programme (TRIP)

4. Parental education/training (including 'Early bird' parent support programmes, communication skills, social skills, coping skills, helping styles, parental empowerment, parental attitude interventions and programmes supporting mother-infant interactions)
5. Therapy/rehabilitation (including occupational therapy, physiotherapy, rehabilitation programmes, motor skills programmes, Paediatric Adapted Physical Education (PAPE), and hydrotherapy)
6. Other parental support (direct support, parental counselling, giving information and advice to parents)
7. Social skills support (Circle of Friends, peer group interventions, communication skills, befriending, circle time, modelling, time out and transition support)
8. Educational programmes (those designed to promote child development, including the 'I Can programme')
9. Early years settings and projects (including the Effective Early Learning Project (EELS), Sure Start local programmes, children's centres, community-based childcare settings, day care settings and play schemes)
10. Specialist pre-school provision
11. Speech and language therapy, including communication skills (for example Responsivity Education/Prelinguistic Milieu Teaching [RPMT])
12. Key workers
13. Multi-agency working and coordination (including early years intervention teams)
14. Counselling and social work support (including child therapy, art therapy and psychosocial interventions).

It is interesting to note that the Early Support programme and team around the child are the most commonly reported in its research and therefore would appear to be making a real difference to the lives of the children and families. However, it is also noteworthy that key workers and multi-agency working and co-ordination appear near the bottom of the rankings. This is also supported by the research findings into parental experiences of services for disabled children (DCSF, 2009: 22) in which parents expressed their wish to have more 'joined up' working that is focused more on good communication and coordination

between services. Parents also felt they had to be very 'proactive and pushy to access services because of problems related to inflexibility of services, a lack of coordination between services and a lack of service availability'.

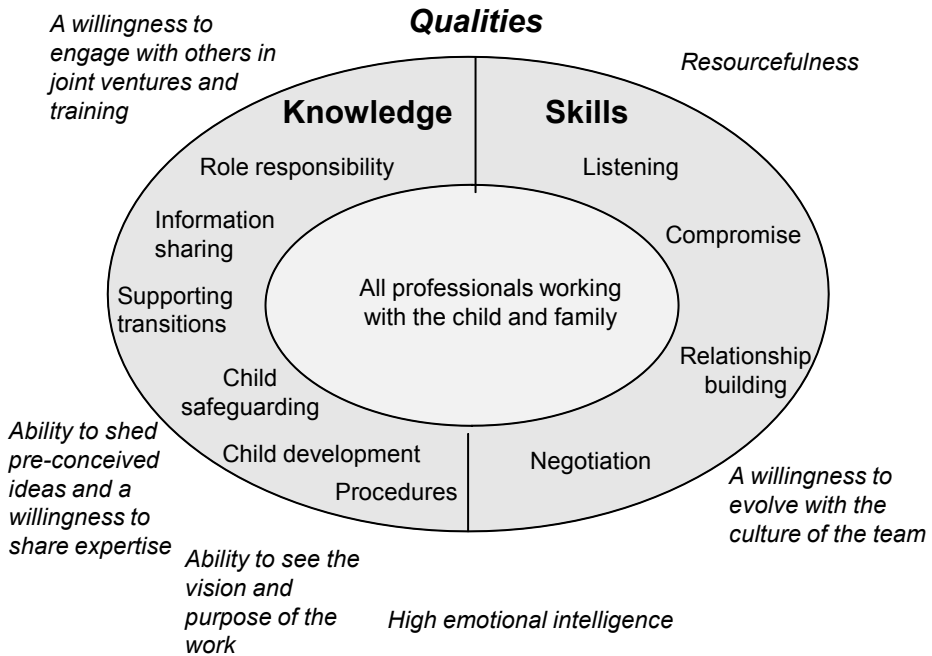
## 7. Conclusion

Clearly, despite its many strengths and positive outcomes for children and families, the system in the UK still needs refinement and further development. In addition to some the difficulties already described here, there remain tensions regarding professionals from different backgrounds working together. Messenger and Robertson (2009) outline some of these as being:

- Difficulties in communication, including differences in terminology and language
- Cultural differences in working practices
- Trust
- Differences in pay and conditions
- Risk
- Clarity of role

Messenger (2010) also suggests that greater attention needs to be paid not only to knowledge, understanding and skills, but to personal qualities and puts forward the possibility that these can be learned, as outlined in the following diagram (Figure 2)

**Figure 2: Threads that draw professionals together (Messenger, 2010)**



Incorporating the further development of these skills, qualities and attributes would appear, therefore, essential in the pre and post qualification and training afforded to all professionals working with vulnerable children and their families. As outlined in this paper, there are already many positive strengths identified in the current UK's policies and practices for supporting vulnerable children which have begun to have real impact not just on the outcomes for children but also in developing more effective inter-professional and trans-professional cooperation and communication. This positive reality is underpinned by the philosophy of the 'team around the child' and the entitlements for children, advocated and upheld by the 'Every Child Matters' (2004) agenda. As the UK enters a new era, with a new coalition government may have new ideas in the field of early childhood intervention.

An already existing indication that integrated children's services may not in practice be so widely supported by the current government is that within days of being in power, the Department for Children, Schools and Families was dissolved and a separate Department of Education was established in early June 2010 with health and social care now in a separate Department. At a local

level, the same introduction of disaggregated services for children is gradually becoming evident in Local Authority provision.

Interesting times may be ahead to see how the policies and practices in the UK develop for educational, health and social services in order that current good practices in identifying and addressing the needs of all children, including the most vulnerable, continue and become more effective. The question as to whether party politics should or will impinge on the progress that has been made in integrating professional services around the child, effecting enhanced early intervention and responses to children's needs in the UK, therefore has to be posed.

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# PRECIOUS Professional Resources in Early Childhood Intervention: Online Tools and Standards

Manfred Pretis\*

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## 1. Background of the Project

The Lifelong Learning Project PRECIOUS ([www.precious.at](http://www.precious.at)) was based on previous efforts within different European partner countries to increase the quality of training for professionals in the field of early childhood intervention.

As the different training systems within the European Union can be assessed as diverse and to a large extent depend on historical developments within the countries themselves, it was the goal of the previous EBIFF project ([www.ebiff.org](http://www.ebiff.org)) to enable assessment and matching processes between personal and institutional curricula and develop a European framework.

Even though only some empirical data is available relating to the correlation of qualification levels of professionals and quality of the service delivered (Bailey et al., 1991; Granlund & Akesson, 1996; Pretis, 1998, McMullen & Alat, 2002, Maude et al., 2010) it can be hypothesised that a specific (professional) training in the field of early childhood intervention should show a higher impact on child and family outcomes.

There is a consensus within the international scientific community that the activities carried out in the field of early childhood intervention should be based on a profound professional training (Peterander, 1996; Eurlyaide, 1997; Pretis, 2006; Applequist et al., 2010), as professionals face diverse challenges in work with families, children and transdisciplinary teams. Speck (1996) highlights that ECI can be assessed as the most complex bio-psycho-social intervention, as it addresses – the child, the family in its social network-contacts and involved professionals.

After the implementation of ECI systems within the last decade in most of EU27, issues of efficiency, quality and training have become more and more relevant

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during the last few years. The report of the European Agency (European Agency, 2005) also highlights the importance of professional qualifications, and respect for national and cultural diversity. In addition the discussion about efficiency and efficacy directly relates to the importance of professional qualifications: higher qualified staff are likely to perform more efficiently, and increase the prevention effect (and therefore reduce the cost factor).

On the other hand the discussion about qualification was also nurtured by the needs of the professionals themselves in their daily work in terms of:

- a. communication skills and skills in listening to the family and working in teams (Carpenter & Herbert, 1994; Carpenter, 1997),
- b. assessing the needs of the family in terms of management skills within ECI centres and structures and
- c. new methodological needs regarding new target groups (e.g. parents from a socially disadvantaged background or mentally vulnerable parents as addressed in the LLL project [www.strong-kids.eu](http://www.strong-kids.eu)).

Generally it can be observed that most European countries have an observable tendency towards standards, both in training and service in the field of early childhood intervention (<http://www.european-agency.org/agency-projects/early-childhood-intervention>).

## **2. The process and results within the PRECIOUS group**

### **2.1 European Masters Curriculum Early Childhood Intervention**

The international PRECIOUS group consisted of 12 partners from 9 different countries which, within several work meetings, created a modular training framework for early childhood intervention. This training framework represents a 120 ECTS masters degree, separated into two stages:

- a. “basic” methodological input (1st year, 60 ECTS) focusing on research, detection and diagnosis, family cooperation, team work and evidence-based individual intervention methods and
- b. “specialisation” (2nd year, 60 ECTS) with three strands:
  - i. Focusing on “management and organisation skills” in early childhood intervention

- ii. “Fostering resilience” in new target groups of early childhood intervention
- iii. Increasing competencies in the field of “established disabilities”

These three specialisations represent to a large extent training needs based on previous research. Table 1 shows the overall curriculum

Table 1: Overall Curriculum

Masters Studies European Masters Early Childhood Intervention Full Time Studies					
BASIC					
Field of Competences	Module No.	Modules/ Courses	CP	Exam performance	
				Sem.	Type
Scientific Research	M 1.1	Scientific research in the field of early childhood intervention	10	2	EXA PRA
	M 1.2	Autonomy and Resource Orientation	5	1	EXA
	Sum		15		
Recognition and Detection	M 2.1	Models of recognition	5	1	EXA PRA
	M 2.2	Early Childhood Intervention as Network Cooperation	5	1	ESY
	Sum		10		
Working together with families	M 3.1	The family as a system	2	1	OEX
	M 3.2	Recognising and responding to the needs of the family	4	1	ESY
	M 3.3	Ways of intervention with and within the family	4	1	WRF
Sum		10			
Working in teams	M 4	Working in teams	10	2	ORF
	Sum		10		
Individual Intervention	M 5.1	Diversity of Support Needs	2	1	EXA
	M 5.2	The Role of the Individual Family Support Plan as Instrument of Diagnosis	2	1	EXA PRA
	M 5.3	Hypothesis Based Support Together with the Family	2	1	PRA
	M 5.4	Matching between Family Needs and Possibilities of the Programme	2	1	PRA
	M 5.5	Ways of Evaluating the Interventions	2	1	EXA PRA
Sum		10			
Personal Competences	M 6	Personal Competences	5	2	WRF
	Sum		5		

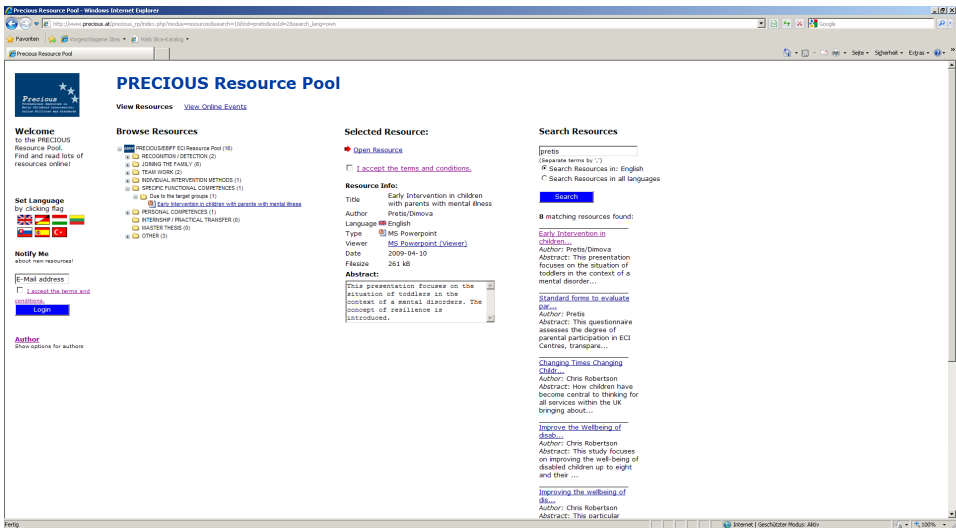


SPECIALISATION					
Field of Competences	Module No.	Modules/ Courses	CP	Exam performance	
				Sem.	Type
Specialisation 1 "Management, Research, Quality Control"	M 7.1.1	Management Processes in Early Intervention	4	2	OEX PRA
	M 7.1.2	Processes of Organisation in Early Intervention	4	2	ESY
	M 7.1.3	Financial and Administrative Management	4	2	ESY
	M 7.1.4	Quality Management	4	2	ESY
	M 7.1.5	Research	4	2	POE
	<b>Sum</b>			<b>20</b>	
Specialisation "Inclusive Support »	M 7.3.1	Children With Autism	4	2	EXA PRA
	M 7.3.2	Children with Perception Disorders	4	2	EXA PRA
	M 7.3.3	Children with Regulation Disorders	4	2	EXA PRA
	M 7.3.4	Children with Multiple Disabilities with additional focus on extremely premature babies	4	2	EXA PRA
	M 7.3.5	Children with complex Learning Difficulties	4	2	EXA PRA
	<b>Sum</b>			<b>20</b>	
Specialisation "Resilient Families"	M 7.2.1	Experiencing Diversity	4	2	EXA PRA
	M 7.2.2	Child Protection	4	2	EXA PRA
	M 7.2.3	What Families Need	4	2	EXA PRA
	M 7.2.4	How to Establish Compliance	4	2	EXA PRA
	M 7.2.5	Making Families Resilient	4	2	EXA PRA
	<b>Sum</b>			<b>20</b>	
Transferproject	M 8	Transfer Project	20	2	PRO
	<b>Sum</b>			<b>20</b>	
Mastersthesis	M 9	Masters thesis	20	1	MAS
	<b>Sum</b>			<b>20</b>	
Abbreviations:		OEX: Oral exam			
MAS: Master thesis		ESY: Essay (Term paper)			
PRA: Internship		WRF: Written Reflection			
EXA: Exam		ORF: Oral Reflection			
PRO: Project Paper		POE: Project Oriented Essay			

## 2.2 PRECIOUS Resource POOL

A further focus of activities addressed the creation and accessibility of training resources, primarily using the internet. Following the structure of the European curriculum, partners and training institutions have the possibility to upload relevant training literature to be used by professionals or training institutions. This is of special interest as for the first time, specific training materials which are normally labelled “grey literature” and mostly used during training programmes, are available for the public, in different languages.

Graph 1: Screenshot of the PRECIOUS resource pool



More than 130 training resources in 8 languages have been uploaded and can be used by interested learners. Therefore, the PRECIOUS resource pool represents a complementary structure to the international professional library of the International Society on Early Childhood Intervention ([http://depts.washington.edu/isei/ptri/PTRL\\_Purpose.php](http://depts.washington.edu/isei/ptri/PTRL_Purpose.php)).

## 2.3 Precious Learning Platform

A third process focused on the creation of a training and communication platform on the internet. Through a range of pilot runs, the possibilities as well as challenges and limitations of training and learning via the online platform were assessed. In small groups with clear didactical approaches, pilot seminars could be organised. However, the training platform also offered the possibility to download relevant course material e.g. relating to early childhood intervention

or new vulnerable groups. Open distance learning tools – in future – can be assessed as powerful instruments to increase the efficiency of professional training, especially regarding issues of knowledge transfer.

### **3. The results of the international cooperation**

As a result of the PRECIOUS group activities towards implementation a Masters program will start in three German universities

- a. as a full-time Masters course at the Medical School Hamburg ([www.medicalschool-hamburg.de](http://www.medicalschool-hamburg.de))
- b. at the University of Applied Science at Gera ([www.gesundheitshochschule.de](http://www.gesundheitshochschule.de))
- c. at the University of Applied Science at Nordhausen ([www.fh-nordhausen.de](http://www.fh-nordhausen.de))

Having finished the accreditation processes in autumn 2010 these two universities will offer Masters degrees starting from 2011. These first Masters degrees will provide an input towards the professional system in Germany as for the first time, after finishing their degree, students will be “early interventionists”. It can be hypothesised that Masters graduates in early childhood intervention will mainly work on highly specific management issues for leading positions in centres in the form of mentors for the centres or other colleagues in the field.

Furthermore, the following initiatives have started within the PRECIOUS project

- a. development of a continuous education initiative in Hungary
- b. Initiatives in Turkey and in Slovakia

Alongside these accreditation processes, initiatives were started in Turkey, Lithuania, Slovakia and Hungary. In Turkey education towards a first Masters degree in early childhood intervention was submitted to the higher education council. In Hungary, due to activities within the project conference in 2009, the Hungarian project partner was asked to submit a specific training programme of early childhood interventionists for accreditation. This training is currently accredited in cooperation with a university in Budapest. In Slovakia early childhood intervention in terms of a sub-specialisation was introduced into the curriculum of therapeutic educators, and specific training offers were created for health professionals. In Lithuania the previous centre-based early childhood intervention was under discussion and within the project time, mobile services were implemented, strengthening the idea of fostering families in their natural contexts.



## 4. Publications and public awareness

In order to stimulate structural changes and impact on national standards, different conferences (in Hungary, Budapest in April 2008, Turkey, Eskesehir in September 2009, in Germany, Gera, September 2010) PRECIOUS also initiated a practical catalogue about standards; defining procedures of strengths and challenges of early childhood intervention systems in Europe. Real impacts can also be observed regarding the increased participation of parents e.g. in the quality assessment of ECI centres or regarding professional training.

## 5. Future challenges

The projects [www.ebiff.org](http://www.ebiff.org), [www.precious.at](http://www.precious.at) and [www.stong-kids.eu](http://www.stong-kids.eu) represent a strong impulse regarding the need and concrete organisation of training in the field of early childhood intervention – addressing the following issues and proposing solutions:

Table 2: Challenges within the training system in Early Childhood Intervention

Training related aspect	Proposed solution within PRECIOUS
National diversity in training and access to the professional field	Use of the Ebiff-assessment instrument to assess the match between personal or institutional portfolio with the European curriculum framework
Lack of specific training courses	For the German, Turkish and Hungarian context courses were designed. For Spain and Austria specific trainings are or will be available.
Lack of professional resources	Availability of an online resource pool
Mainly face-to-face organised trainings	Use of ODL structures for knowledge-related training components.

Even though in some EU27 member countries structured efforts towards comparable professional training can be observed, issues still remain:

- diversity of languages
- affordability for professionals (directly connected with the “pricing” of training)
- or concrete organisation of multilingual courses (especially regarding the

need of new member states in Central and East Europe).

It must not be forgotten that one major effect of our European cooperation is to create networks and better understanding.

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