Early Intervention Therapy Program Guidelines

Ministry of Children and Family Development

January 2009

BRITISH COLUMBIA

Acknowledgements

The Early Intervention Therapy Program Guidelines were developed with the generous support of practitioners and families. We would like to thank the following Advisory Group members for their valuable input:

Lorraine Aitken, Supported Child Development Program

Cynthia Bakker, Clements Centre Society

Jennifer Boutilier, Queen Alexandra Centre for Children's Health

Heather Branscombe, Fraser Valley Child Development Centre

Dana Brynelsen, Infant Development Program

Christie Diamond, Office of the Provincial Paediatric Therapy Consultant

Nancy Gale, Cariboo Chilcotin Child Development Centre

Caron Graham, Parent/Family Support Institute

Ken Kabool, Ministry of Children and Family Development

Llaesa North, Prince George Child Development Centre

Lynn Rogers, BC Children's Hospital

Lori Roxborough, Sunny Hill Health Centre for Children

Adriana Scuka, Fraser Health Authority

Astrid St. Pierre, BC Children's Hospital

Carol Stinson, Parent/Burnaby Association for Community Inclusion

Rochelle Stokes, Reach Child and Youth Development Society

Phyllis Straathof, Child and Family Rehabilitation Services

Margaret Warcup, Kitimat Child Development Centre

Ellie Wray, BC Centre for Ability

We would also like to acknowledge the valuable input provided by:

Linda Bachmann, Fraser Health Authority

Margaret Chesterman, Vancouver Coastal Health Authority

Marcia Dawson, Success By 6

Diana Elliott, Aboriginal Infant Development Program

Pam Moore, Comox Valley Aboriginal Head Start Program

Penny Stewart, Health Canada

Deanne Zeidler, Vancouver Coastal Health Authority

Photo Credit: Llaesa North.

Contents

INTRODUCTION 1

Purpose of the Guidelines 1

Program Description 1

Program Goals and Objectives 2

Service Delivery 2

EARLY INTERVENTION THERAPY TEAM MEMBER ROLES 3

Early Intervention Therapists 3

Family Support Professionals 4

ADDITIONAL TEAM MEMBERS 5

Autism Funding Program 5

Community Brain Injury Program 6

Early Intensive Behavioural Intervention Program 6

Public Health Speech and Language Services 6

EARLY INTERVENTION THERAPY TEAM APPROACH 7

Multidisciplinary 7

Interdisciplinary 7

Transdisciplinary 7

SERVICES OFFERED TO CHILDREN AND FAMILIES 8

A. Screening 8

B. Referral 8

C. Assessment 8

D. Family Education and Support 9

E. Arranging Services and Supports with Families 9

F. Intervention 9

G. Transition Planning 11

H. Discontinuation of Services 11

I. Outreach and Community Capacity Building 12

ESSENTIAL COMPONENTS OF EFFECTIVE SERVICE DELIVERY 13

Standards and Competencies 13

ACCOUNTABILITY AND QUALITY ASSURANCE 28

Accreditation 28

Program Evaluation 28

PROGRAM RESOURCES 30

Business Practice 30

Child Welfare 31

Evidence-Based Practice and Research 31

Program Evaluation 31

Service Delivery 32

Specialized Provincial Services 34
Student Fieldwork Resources 35
Transition to School 35

BIBLIOGRAPHY 36

APPENDIX A: EARLY INTERVENTION THERAPY PROGRAM LOGIC MODEL 40

APPENDIX B: OVERVIEW OF SERVICES FOR CHILDREN AND YOUTH WITH SPECIAL NEEDS AND THEIR FAMILIES 41

APPENDIX C: A SAMPLE INDIVIDUALIZED FAMILY SERVICE PLAN TEMPLATE 44

Individualized Service Plan 44

Introduction

PURPOSE OF THE GUIDELINES

This handbook is intended to guide the consistent delivery of quality Early Intervention Therapy (EIT) services across British Columbia. It replaces the 1995 Early Intervention Program Guidelines, developed by the Ministry of Health and Ministry Responsible for Seniors. The handbook revision was based on a best practice literature review, cross-jurisdictional research, and extensive consultation with stakeholders.[1]

This handbook is a resource for organizations providing EIT services and Ministry of Children and Family Development staff responsible for administering EIT service contracts. It may also be of interest to families of children with special needs and other community members to support their understanding of the EIT Program's standards of service delivery. EIT services must be provided in accordance with the guidelines set out in this handbook.

PROGRAM DESCRIPTION

The Early Intervention Therapy (EIT) Program provides community-based services and supports to children between birth and school entry[2] who have, or are at risk for, a developmental delay and/or disability, and their families and communities.[3] Services and supports include:

- screening;
- referral;
- assessment;
- family education and support;
- service planning;
- direct therapeutic intervention;
- consultation;
- monitoring;
- transition planning; and
- community training.

Professionals delivering EIT services include occupational therapists, physiotherapists, speech-language pathologists, and family support professionals. Please note the following terms that are used throughout this handbook:

- 'Organization' refers to the organization providing EIT services, including management, administrative and support staff, therapists, and family support professionals.
- 'Family' refers to the persons who play a significant role in a child's life and act as his/her support network. It may include the child's parents, guardians, siblings, extended family, legally authorized representatives, or others. Due to the diversity of family structures, it may include people who are not legally related to the child.

1 Best practices include activities or guidelines that produce a specific outcome and that are supported by research, experience with a particular intervention, and/or expert opinion.

2 "School entry" refers to the date on which a child is enrolled in an educational program, in accordance with the ***School Act, 1996***.

3 A developmental delay is an infant or young child's lack of expected progress in cognitive, physical, communication, social/emotional, or adaptive development (Tennessee's Early Intervention System, 2001). 'Disability' is an umbrella term for impairments, activity limitations, or participation restrictions including environmental and personal factors. A disability may be temporary or permanent, reversible or irreversible, and progressive or regressive.

PROGRAM GOALS AND OBJECTIVES

Recognizing the importance of the early years, the primary goal of the Early Intervention Therapy (EIT) Program is to optimize the growth and development of children from birth to school entry who have, or are at risk for, a developmental delay and/or disability.

The program's objectives, which support this goal, are to:

- emphasize and build on the existing strengths of children and families, in order to enhance their knowledge, skills and participation in community life;
- reduce or eliminate the impact of children's existing disabilities, health conditions (including traumatic injury), and birth factors that could lead to the development of a disabling condition or delay; and
- reduce or eliminate environmental factors that negatively affect children's functioning and participation.

The EIT Program provides occupational therapy, physiotherapy, speech-language pathology, and family support services in order to achieve the goal and objectives.

For more information, see Appendix A: Early Intervention Therapy Program Logic Model, on page 40.

SERVICE DELIVERY

Early Intervention Therapy services and supports are delivered through contracted organizations, which may include health authorities. Services are provided in home and community settings, such as preschool, child care, and child development centres. Organizations work closely with families and community resources to plan and deliver services and supports that best suit the needs, priorities, and capacities of individual children and their families.

Early Intervention Therapy Team Member Roles

This section provides an overview of the respective roles of Early Intervention Therapy (EIT) team members, including therapists and family support professionals. Though their specific roles may differ, EIT team members work collaboratively in supporting positive outcomes for children, families, and communities. All of the following professionals may not be present on each child's EIT team, as the team's composition is determined by the unique needs of the child and family.

EARLY INTERVENTION THERAPISTS

Occupational therapists, physiotherapists, and speech-language pathologists provide services to help children achieve their highest attainable level of participation within home, preschool, child care, and other community settings. These services include screening, assessment, consultation, therapy, monitoring, individual program planning, education and training, and administration (e.g., report writing and program evaluation). Early intervention therapists often act as liaisons within home, school and community settings. This includes advocating for accessible environments and promoting the community's capacity to meet the needs of children and families through education and outreach. They also assist in the interpretation of medical and other health information and its implications for the child.

Early intervention therapists are involved in professional development and research activities to support high quality services and the advancement of paediatric rehabilitation. For more information on specific services provided by early intervention therapists, see Services Offered to Children and Families on page 8.

In accordance with the World Health Organization's International Classification of Functioning, Disability and Health (2001), therapy services consider the dynamic interaction between health conditions and environmental and personal factors that influence the child's functioning. This includes examining the child's physiological function and anatomical structures; his/her capacity and performance with executing activities; and the physical, social, attitudinal, and familial environment in which he/she lives.

Therapy services strive to:

- emphasize children's strengths by focusing on their participation in multiple environments;
- assist children to participate in their communities by identifying and removing environmental and personal barriers, increasing facilitators in their environments, and enhancing their competence at the personal level; and
- focus on social inclusion and participation, which may assist in changing attitudes towards disability.

Occupational Therapists

Occupational therapists (OTs) provide services that help caregivers to develop the child's highest attainable level of participation in all daily activities.[4] OTs provide support to children and families in the following areas: fine motor skills (hand function), activities of daily living (e.g., dressing, feeding and swallowing), perceptual/cognitive skills (e.g., design copying and sequencing), sensory-motor skills (e.g., motor planning and tactile sensitivity), functional play skills, specialized equipment and environmental modifications (e.g., splinting, assistive devices, technology and home modifications), and posture control to support function.

4 A caregiver is a person who has assumed responsibility for the care of a child in the child's natural environment. This may include the child's natural, adoptive, or foster family members, extended family members, or child care professionals (adapted from ***Child, Family and Community Service Act***, 1996).

Physiotherapists

Physiotherapists (PTs) provide services that focus on the identification and promotion of optimal movement development. PTs provide support in the areas of neuromuscular, musculoskeletal, cardiovascular, respiratory functioning, and posture control. They also introduce active lifestyle techniques in order to promote the child's highest attainable level of participation, and provide and assist in the use of splints, braces, prosthetic devices, and other equipment to improve positioning, function, and mobility.

Speech-Language Pathologists

Speech-language pathologists, also known as speech therapists, provide services that focus on verbal and non-verbal communication skill development and the oral motor skills required for drinking and eating. They provide support in the areas of language understanding and use, social communication use (e.g., greeting people and playing with peers), speech clarity (ability to produce and combine speech sounds and use the voice), facial expression, body language and gestures, alternative or augmentative communication (e.g., sign language, picture symbols and verbal output devices), fluency, pre-literacy skills, and swallowing and feeding issues.

Therapist Assistants

Therapist assistants perform components of therapy procedures and related tasks selected by a supervising therapist that include both direct and non-direct activities. The delegation of tasks to a therapist assistant must be in accordance with the standards of the relevant self-regulatory body. For more information on self-regulatory bodies, see Essential Components of Effective Service Delivery on page 13.

Therapy Students

Therapy students apply the knowledge and skills learned in the classroom and learn new skills in a supervised clinical placement setting. Therapy students are enrolled in a rehabilitative science or therapy program from an accredited, degree granting institution.

FAMILY SUPPORT PROFESSIONALS

Family support professionals assist families to acquire parenting, child development and advocacy skills, and address factors which may affect their capacity to care for their child. They focus on empowering and enhancing family functioning, which supports the effectiveness of therapeutic interventions. Research on the needs of families of children with disabilities has increasingly called for the provision of such a dedicated professional to serve as a single point of contact (Mukherjee et al., 2006). For more information on services provided by family support professionals, see Services Offered to Children and Families on page 8.

Family support services may be provided by the following professionals:

- family support professionals or social workers employed by organizations providing Early Intervention Therapy (EIT) services;
- Infant Development Program (IDP) and Supported Child Development (SCD) consultants;
- Aboriginal IDP and SCD Program consultants;
- key workers;[5]
- therapists from the EIT Program; and
- other community professionals.

The child's team should identify the professional responsible for providing family support services, in order to minimize overlap in the roles of team members.

5 A key worker helps families maneuver through a complex array of systems by offering support and facilitating collaborative working relationships among service providers and across organizations and sectors. Families of children and youth who have, or are suspected of having, Fetal Alcohol Spectrum Disorder (FASD) or similar neurological conditions may be eligible for key worker services available through the Ministry of Children and Family Development.

Additional Team Members

A range of health, early childhood development and intervention professionals may be involved with a child and family receiving Early Intervention Therapy (EIT) services, including:

- audiologists;
- behaviour consultants;
- behaviour interventionists;
- Child and Youth Mental Health clinicians;
- early childhood educators;
- developmental psychologists;
- dieticians;
- Infant Development Program (IDP) and Supported Child Development (SCD) Program consultants;
- Aboriginal IDP consultants;
- Aboriginal SCD consultants;
- paediatricians;
- physicians;
- private therapy practitioners; and
- public health nurses.

This list is intended as an example of other possible professionals on a child's team. For more information on programs and services for children with special needs, see Appendix B: Overview of Services for Children and Youth with Special Needs and Their Families, on page 41.

ADDITIONAL OCCUPATIONAL THERAPISTS, PHYSIOTHERAPISTS, AND SPEECH-LANGUAGE PATHOLOGISTS

Early Intervention Therapy (EIT) service providers often work closely with occupational therapists, physiotherapists, and speech-language pathologists associated with the following programs in order to coordinate services for children and families:

- Autism Funding: Under Age 6 Program;
- Community Brain Injury Program;
- Early Intensive Behavioural Intervention Program; and
- Public Health Speech and Language Programs.

AUTISM FUNDING: UNDER AGE 6 PROGRAM

The Autism Funding: Under Age 6 Program provides funding directly to families of children with Autism Spectrum Disorder to purchase autism intervention services from professionals listed on the Registry of Autism Service Providers,[6] in accordance with the child's behavioural plan of intervention.[7] For more information, visit *www.mcf.gov.bc.ca/autism/index.htm*.

6 The Registry of Autism Service Providers (RASP) is a list maintained by ACT – Autism Community Training on behalf of the Ministry of Children and Family Development, from which parents of children receiving Autism Funding: Under Age 6 are required to select professional service providers (behaviour consultants, speech-language pathologists, occupational therapists, and physiotherapists). In order to be included on the RASP, professionals must demonstrate that their education and experience meet the qualifications described by the ministry. The RASP is available at *www.actcommunity.net*.

7 A behavioural plan of intervention is a plan developed and written by a behaviour consultant, through interdisciplinary collaboration and parental input. It promotes the child's development by identifying both broad and specific goals to improve his/her daily functioning and increase his/her independence in home, school, and community settings.

COMMUNITY BRAIN INJURY PROGRAM

The Community Brain Injury Program provides funding and coordination of short-term, community-based rehabilitation and support services for children and youth with an acquired brain injury. For more information, visit *www.centreforability.bc.ca/*.

EARLY INTENSIVE BEHAVIOURAL INTERVENTION PROGRAM

The Early Intensive Behavioural Intervention Program provides intensive interdisciplinary intervention services for children under age six diagnosed with Autism Spectrum Disorder, in seven communities. For more information, visit *www.mcf.gov.bc.ca/autism/programs/index.htm*.

PUBLIC HEALTH SPEECH AND LANGUAGE SERVICES

Speech-language pathology (SLP) services for young children are also available through Health Authority Public Health programs. Services include:

- assessment of children's speech and language development;
- SLP intervention for children with speech and/or language delays or disorders; and
- educational workshops for caregivers regarding children's speech and language development.

Typically, Public Health SLP programs deliver intervention services to children with a primary speech delay, who do not also require occupational therapy or physiotherapy services. In some communities, Public Health SLP services may also be provided to children who require multiple types of therapy services.

The Early Intervention Therapy and Public Health SLP programs often work closely together to coordinate services at the administrative and service delivery levels. Providing a central intake process and clearly defining the responsibilities of the speech-language pathologists from each program can enhance service coordination, in order to meet the needs of communities served.

Early Intervention Therapy Team Approach

Providing services for children with special needs often requires the expertise of professionals from several disciplines, depending on each child and family's needs. Research evidence indicates that teamwork results in more effective and efficient services than those provided individually (Cook, 1996 and Enderby, 2002, as cited in Soever, 2006).

The Early Intervention Therapy Program uses a collaborative model in order to coordinate services and improve child and family outcomes. An interdisciplinary or transdisciplinary approach is used, based on the child and family's needs and preferences, and team members' skills. This section describes common approaches to teamwork, including multidisciplinary, interdisciplinary and transdicisciplinary. This is intended to promote an understanding of the dynamic nature of teamwork in health and intervention teams.

MULTIDISCIPLINARY

The multidisciplinary approach involves individual assessment, service planning and service delivery, with results not necessarily shared among team members. The relatively low level of interaction among team members often results in the child and family providing identical information to multiple professionals. Service planning and delivery may not be based on a comprehensive, holistic understanding of the child and family's strengths and needs.

INTERDISCIPLINARY

Team members adopting the interdisciplinary approach collaborate in assessment and service planning. While each professional may deliver services independently, assessment and intervention results are shared and discussed among all team members (Reilly, 2001 as cited in King et al., 2006).

The interdisciplinary approach promotes communication among team members. However, a potential limitation associated with its use includes the requirement for the child and family to interact with, and provide information to, multiple professionals in the service delivery process.

TRANSDISCIPLINARY

The transdisciplinary approach offers the highest level of collaboration. Team members interact in assessment and service planning, with one assigned primary responsibility for providing intervention services within his/her professional scope of practice, based on the child and family's needs. Frequent communication exists, with assessment and intervention results shared and discussed among all team members.

Leaders in early intervention generally favour the transdisciplinary approach, due to its emphasis on interaction among team members (Harbin et al. as cited in Rapport et al., 2004). The primary service provider must possess the necessary competencies to address the child and family's needs in consultation with the other team members, while respecting professional licensure requirements. The following elements are also necessary for the successful implementation of the transdisciplinary approach:

- common team member goals;
- well-defined team member roles in order to minimize conflict;
- effective communication; and
- institutional support for transdisciplinary teamwork, including training in its use.

Services Offered to Children and Families

A. SCREENING

Screening is vital to the timely, effective delivery of Early Intervention Therapy (EIT) services, as it is a first step in determining the presence of a delay or disability, and enables early identification and diagnosis. Therapists screen children and families in order to determine whether they may benefit from EIT services. Screening may be done through observation of the child, a face-to-face or telephone interview, or a formal screening tool.

B. REFERRAL

A child may be referred to the Early Intervention Therapy (EIT) Program if there is concern that his/her development is delayed, or if there is an identified disability.

The EIT Program accepts referrals from all sources, including families and professionals involved with the child and family, such as paediatricians, physicians, public health nurses, child care providers, or other professionals. Referral from a professional should be based on clinical judgment or an informal screening process, whereby the presence of a potential delay or disability is established. If the family is not the referral source, their permission must be sought prior to initiating the referral. Children and families may be referred to other programs, if available, as appropriate.

C. ASSESSMENT

A supportive working partnership with family members is fostered during the assessment process since it is critical in terms of identifying the child and family's needs, strengths and goals. It is also an opportune time to model strategies and provide the family with information about child development.

Assessments synthesize past records, evaluations, interviews, observations of current behaviour, knowledge of professionals familiar with the child and family, and the results of standardized tests, as appropriate. Team members determine which assessment tool to use, recognizing that standardized assessment tools may not be appropriate for all children and families. Only necessary assessments are carried out.

Families are encouraged to participate in the assessment and indicate whether the child's performance is reflective of his/her typical behaviour. The assessment provides an opportunity to educate family members about their child's particular developmental level and demonstrate ways in which early intervention therapy can be incorporated into the child's day.

All relevant therapists participate in a comprehensive assessment upon the child's referral to the Early Intervention Therapy Program. This involves assessing developmental domains in order to gain a thorough understanding of the child and family's needs. Clinical judgment is required to provide meaning to the various results and develop recommendations related to the intervention.

Children and families should not be required to wait until a comprehensive assessment can occur before receiving at least preliminary intervention services (Guralnick, 2001). Such services should address a family-identified priority, and may include an initial consultation or group-based intervention to:

- address language and/or motor development; or
- link families with community resources.

Assessments provide a baseline for monitoring and evaluating the progress of intervention and may be used for diagnostic purposes. Ongoing assessments are conducted to measure the child's developmental progress over time.

D. FAMILY EDUCATION AND SUPPORT

Early Intervention Therapy (EIT) service planning and delivery is a collaborative process between families and professionals. Caregiver education is therefore emphasized, as it enables informed joint decision-making among all team members. Professionals on the EIT team work in partnership with the family to enhance their knowledge and skills in order to promote their child's growth, development, and functioning. Families are provided with relevant, accurate information to support their role on the team.

Family support services aim to enhance the family's ability to meet their child's needs by encouraging a sense confidence in their role as caregivers. Specific services may include:

- assisting the family to develop effective means of advocating on their own behalf;
- advocating with and for the child and family, where needed;
- providing emotional support, guidance, and advice regarding the impact of the child's disability and/or developmental delay on the family;
- assisting the family to find and access community resources (including counselling);
- assisting the family to navigate health, education, and social service delivery systems; and
- facilitating connections between families.

E. ARRANGING SERVICES AND SUPPORTS WITH FAMILIES

The therapist or family support professional works in partnership with the family to plan appropriate services and supports. The planning process results in the development of an Individualized Family Service Plan (IFSP) or equivalent planning document. Team members emphasize family choice in the selection of a planning document that outlines the desired outcomes, the services and supports needed to meet the outcomes, and the roles and responsibilities of team members. It may also be useful to include a communication plan in order to facilitate collaboration and open dialogue among team members. For more information, see Appendix C: A Sample Individualized Family Service Plan Template on page 44.

Families should be engaged at the outset of the assessment process, to ensure that there are no 'surprises' for them at the initial service planning meeting. Therapists and family support professionals, including those who were not involved in the assessment or initial service planning for a child, are encouraged to refer to the existing service plan when designing services with the family. The determination of required services and supports is based on the child and family's needs, priorities and resources, as well as the assessment and diagnostic results, which incorporate the service provider's professional judgement.

F. INTERVENTION

The Early Intervention Therapy (EIT) Program offers children and families a range of individualized intervention services, including direct therapy, group therapy, consultation, equipment prescription, loan and adaptation, and monitoring. Intervention services aim to promote the child's functional skills, community participation, peer interaction, and quality of life.

The family and therapist work collaboratively to implement the service plan, with services designed to include the child, caregiver, and relevant therapist.

Intervention services support a social environment that promotes engagement, interaction, communication, and learning.

Direct Therapy

Therapists provide one-to-one services to assist children in achieving their highest attainable level of independent functioning. Direct therapy services may consist of:

- functional skill development and/or enhancement; and
- education (coaching, teaching, demonstrating, and promoting the use of a skill which the child is capable of performing, yet is not performing consistently).

Direct therapy is most appropriate when specialized techniques, requiring the skills of a qualified therapist to administer, are needed, or the child requires individual skill development in order to be included in a group.

Group Therapy

Therapy services are provided to a small number of children in group settings. This method of service delivery promotes the acquisition of skills in a peer environment, enhances children's motivation, and encourages efficient service delivery. The emphasis may be on the development of social skills related to interaction and communication, movement-based learning, sensory processing, or school-readiness activities.

Consultation

Therapists provide guidance, support, and education to assist caregivers in implementing specific intervention techniques. Consultation enhances direct therapeutic intervention by integrating services into the child's daily routine, facilitates the caregiver's learning of appropriate responses to the child's behaviour and abilities, and promotes the community's inclusion of the child and family.

The therapist is ultimately responsible for the outcome of the intervention and remains in regular contact with the person carrying out the plan to ensure that services are provided consistently. The therapist's responsibilities related to consultation include:

- training family members, preschool teachers, child care providers, and others within the child's natural environment or team to administer the therapeutic program; and
- overseeing, and evaluating the effectiveness of, delegated tasks.

Therapists may use coaching models in the consultation process. Coaching involves the caregiver and therapist working jointly to improve current intervention practices and develop new skills through self-assessment. The therapist supports the caregiver to develop the confidence and capacities necessary to enable the child's optimum development. The components of coaching are initiation, observation, action, reflection, and evaluation (Coaching in Early Childhood, 2006).

Equipment Prescription, Loan and Adaptation

Therapists recommend a variety of equipment, such as mobility and therapeutic equipment, augmentative communication devices, splints and orthotics, as well as their adaptations. They may also make recommendations that support barrier-free design and accessible environments.

Therapists are responsible for the following, as required:

- prescribing required equipment and their adaptations;
- providing information regarding equipment funding sources;
- accessing loan equipment on behalf of the child and family; and
- fitting and modifying equipment to meet the child's needs.

Monitoring

A child enters a monitoring phase for a specified timeframe if he/she is not actively receiving any other intervention services and concerns regarding his/her development persist. Monitoring may occur regardless of whether the child has previously received EIT services.

Tools such as the Ages and Stages Questionnaire may be used to monitor children who are not actively receiving intervention services. Monitoring permits the identification of children who may benefit from intervention at a later date.

G. TRANSITION PLANNING

Transition planning assists the child and family to prepare for discharge from the Early Intervention Therapy (EIT) Program and transition to alternate services, if needed. Transition planning supports developmental transitions such as the transition from preschool to kindergarten.

In preparation for transition, the therapist or family support professional discusses the child and family's ongoing needs with the family and offers information regarding potential resources, including school district contacts if applicable. Therapy resources that may be relevant include the School-Aged Therapy Program, the School-Aged Extended Therapies benefit provided through the At Home Program, the Community Brain Injury Program, and the Autism Funding: Ages 6-18 Program. For more information on these programs, see Appendix B: Overview of Services for Children and Youth with Special Needs and Their Families, on page 41.

A transition planning meeting should be held at least ninety days before the anticipated date of discharge from the EIT Program and include the family, EIT and school-based team members, and other professionals involved with the child and family. If the child is transitioning to school, the meeting should be held in the spring prior to his/her school entrance. This meeting results in the preparation of an individualized transition plan that identifies needed services and supports, as well as the means by which these will be acquired and maintained. It may also plan for transition to the school community and identify the school district resources available. In order to ensure consistency between the outcomes of intervention and the transition process, it may be useful to include the transition plan within the family's service plan.

Long-term planning should be considered throughout the family's involvement with the EIT Program. Effective planning reduces the anxiety and stress related to program transitions for the child and family and promotes service continuity.

H. DISCONTINUATION OF SERVICES

Early Intervention Therapy (EIT) services are discontinued under the following circumstances:

- the child's developmental progress, as determined through appropriate assessments, indicates that EIT services are no longer needed;
- the family moves to another program or chooses to discontinue services; or
- the child reaches school entry.[8]

The EIT Program team facilitates this process by providing a discharge letter to the family and preparing a final report for distribution to the family and others, as determined by the family.

I. OUTREACH AND COMMUNITY CAPACITY BUILDING

Therapists and family support professionals may provide outreach services in both their local communities and communities outside of their local areas. Outreach includes events and services designed to engage and encourage families to access Early Intervention Therapy (EIT) services. Therapists and family support professionals integrate outreach services within existing community programs in order to enhance and coordinate services, and build the community's capacity to meet the needs of children and families.

EIT service providers work collaboratively with Aboriginal communities to support them in developing and delivering EIT services.

8 "School entry" refers to the date on which a child is enrolled in an educational program, in accordance with the ***School Act***.

Essential Components of Effective Service Delivery

STANDARDS AND COMPETENCIES

This section outlines the standards and associated competencies required for the effective delivery of Early Intervention Therapy (EIT) services and supports. The EIT Program standards are based on best practices and support positive outcomes for children, families and communities. They apply to all activities of organizations providing EIT services.

A standard refers to the established criterion or standard of performance which must be attained. A competency is a cluster of related skills, knowledge, and abilities that are obtained through experience or training, and enable therapists and/or family support professionals to successfully perform to the required standard (adapted from Accreditation Council for Canadian Physiotherapy Academic Programs et al., July 2004). The EIT Program competencies relate specifically to the delivery of EIT services. Information regarding professional self-regulatory bodies is also provided to support the maintenance and enhancement of clinical competencies.

The EIT Program standards are intended to supplement those developed by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) and the Canadian Council on Health Services Accreditation (CCHSA). Where possible, links to the related standards of CARF and/or COA are provided. For more information on accreditation, see Program Resources on page 30.

Consistent with the service delivery standards, the EIT Program provides services that are:

- child-focused;
- family-centred;
- strengths-based;
- based on a cultural safety approach to service delivery with Aboriginal communities;
- outcomes-focused;
- coordinated and based on interdisciplinary or transdisciplinary collaboration;
- based on the integration of clinical expertise with current research evidence;
- delivered in settings that are relevant and comfortable for the child and family;
- supportive of the child's inclusion in his/her community;
- delivered by competent and qualified staff;
- supported by established waitlist and caseload prioritization and management strategies; and
- based on continuous quality improvement.

STANDARD 1: The organization uses a child-focused approach.

Competencies

- Understanding of, and respect for, the child's rights as stated in the United Nations Convention on the Rights of the Child.
- Understanding of child development in order to design interventions that are appropriate for the child's developmental level.
- Ability to determine the child's interests, preferences, behaviours, strengths, challenges, functional status, and communication and learning styles, and deliver services that are informed by these.
- Ability to work with the child and family in developing a comprehensive, individually tailored intervention plan.
- Awareness that some children, such as children in care, may be at a heightened risk for developmental delays and/or disabilities.[9]

Demonstration of Competencies

- Demonstrate respect for the child's needs/preferences and behaviours.
- Use intervention methods and materials that the child prefers.
- Identify and implement methods for establishing a supportive learning environment that is responsive to the child's developmental needs.
- Provide ongoing observation of the child's response to intervention and alter the services accordingly.

Definition

- A child-focused approach involves the individual tailoring of services for the child, based on his/her interests, strengths and changing needs; the demands of his/her current environment; and recognition that children grow and develop within the context of their culture, relationships and multiple, complex environments.

Links

- CARF: Medical Rehabilitation; Section 3.F; Standards 1 (a), 2, 6 (a, b and c), and 20.
- CARF: Child and Youth Services; Section 2.A; Standards 3 and 9
- COA: PA-CFD; Standard 13.02.

9 As noted by the Representative for Children and Youth and the Office of the Provincial Health Officer (2007), children in care are over six times more likely to have special needs than the general population.

STANDARD 2: The organization uses a family-centred approach.

Competencies

- Ability to recognize the family as experts on their child.
- Knowledge of how caregiver-child interactions and family-initiated experiences support the child's development.
- Knowledge of family development, family dynamics, and the potential effect of a child's disability on the family system.
- Understanding of how personal values and experiences with disability may influence which services are offered and accepted (Malone et al., 2000).
- Ability to honour and affirm family diversity in both the design and delivery of services and adapt approaches to the cultural, ethnic, and socioeconomic contexts of the family and community.
- Understanding of the influence of family diversity on early child development and intervention practices, and attitudes towards disability and developmental delay.
- Recognition of the diversity of family structures, and that some families may include extended family and community members.
- Understanding of the child's needs within the context of the family, and the ability to incorporate these into services.
- Ability to identify, and deliver services that are informed by, the family's functioning and communication styles, strengths, needs, beliefs, values, preferences, shifting priorities, and expertise.
- Understanding that the preferred level of involvement in the intervention process varies within and between families (Cahill, 1996, as cited in Gerlach, 2007).
- Ability to develop a strong, positive relationship with families, based on:
  - mutual support and respect for each other's roles;
  - a commitment to joint decision-making; and
  - respect for the family's preferred level of involvement.

Demonstration of Competencies

- Use activities and materials that respect the full range of family structures and lifestyles.
- Provide the family with opportunities to participate in decision-making and encourage family members' involvement in assessment, goal-setting and intervention.
- Listen and respond to the family's concerns and provide timely, accurate, and relevant information in a format that is accessible for the family and free of clinical jargon.
- Assist the family to understand and apply information regarding early childhood development, developmental delays, disabilities, assessment methods, test results, the effectiveness of various intervention methods, and service and support options (including those that are currently unavailable and need to be developed).
- Provide training or workshops to promote the family's understanding of their role on the intervention team.
- Inform family members of available options to support their participation on the intervention team in accordance with their own styles and preferences, including preferred levels of involvement in the intervention process.

- Adapt programs in response to family input and feedback.
- Create opportunities for caregivers to establish networks with other caregivers and community resources.

Definition

- A family-centred approach involves recognition of the family as experts on their child and the provision of services that are informed by the family's particular strengths, needs, beliefs, values, preferences and priorities. These may relate to culture, ethnicity, socioeconomic status, geography, language, spiritual traditions and family structure.

Links

- CARF: Medical Rehabilitation; Section 3.F; Standards 1(b) and 2.
- CARF: Child and Youth Services; Section 2.A; Standards 3 and 5 (a and b).
- COA: PA-CFD; Standards 13.03 and 13.05.

STANDARD 3: The organization recognizes and builds upon the individual strengths, capacities and resources of the child, various family members and the community, and affirms the child's developmental potential.

Competencies

- Ability to recognize individual and family strengths and resources.
- Understanding of methods that promote the family's empowerment to participate in the design and delivery of services.

Demonstration of Competencies

- Affirm the child's developmental potential to his/her family.
- Identify and utilize the strengths and resources of the child's family, formal and informal support networks, and community resources.
- Design services that reinforce the child and family's strengths and resources.

Links

- CARF: Medical Rehabilitation; Section 3.F; Standard 3 (a.1).
- CARF: Child and Youth Services; Section 2.A; Standard 5 (a.1).
- COA: PS-CFD; Standard 13.02.

STANDARD 4: The organization uses a cultural safety approach when working with Aboriginal children, families, and communities.

Competencies

- Understanding and awareness of own personal cultural perspectives.
- Understanding of the influence of historical and socio-political issues on the planning and delivery of services with Aboriginal children, families, and communities.
- Ability to incorporate the concepts of development and health from an Aboriginal perspective into services for Aboriginal children, families, and communities.
- Ability to develop and maintain relationships based on trust and respect with community members in order to plan and deliver culturally relevant services.
- Recognition that each family is unique within a cultural context.

Demonstration of Competencies

- Reflect on personal cultural perspectives and how these may impact the assumptions, values, and beliefs that inform service planning and delivery.
- Incorporate the family's cultural and ethnic traditions into services by, for example, noting them in the planning document.
- Engage the child and family in culturally relevant community-based activities.
- Seek out opportunities to network and build relationships of trust and respect with community members.
- Consult and collaborate with Aboriginal Elders, Chief and Council, and other key community members in the development and planning of services for Aboriginal children and families.
- Seek out opportunities to increase the number of staff who are of Aboriginal ancestry, in order to support the community's capacity to meet the needs of Aboriginal children and families.

Definition

- A cultural safety approach involves the examination and understanding of the historical power inequities and individual and institutional discrimination that may impact therapeutic relationship dynamics (adapted from Gerlach, 2007).

Links

- Standards that relate specifically to cultural safety were not identified.

STANDARD 5: The organization provides services that are goal-directed and based on practical outcomes that are meaningful to the child and family and informed by professional judgment.

Competencies

- Understanding of child development to ensure that goals are appropriate and challenging.
- Knowledge of the family's priorities for their child.
- Knowledge of, and ability to apply, outcome measures and program evaluation methods.
- Flexibility in determining and modifying outcomes as needed.

Demonstration of Competencies

- Work with the family to develop specific strategies for achieving outcomes, addressing where, how often, and by whom services will be provided (Hanft and Feinberg, 1997).
- Demonstrate respect for diverse perspectives when identifying the family's priorities for their child.
- Involve the child and family in establishing, prioritizing and evaluating service outcomes in order to determine whether intervention has resulted in effective, meaningful change.
- Assist the family to prioritize outcomes, with each one linked to a specific type, frequency, and intensity of service.
- Adjust the intensity, frequency, and duration of services in order to make progress towards accomplishing established outcomes.
- Evaluate and synthesize outcome data to determine the effectiveness of services and inform program modifications.

Links

- CARF: Medical Rehabilitation; Section 3.F: Standards 11, 12, and 13.
- CARF: Child and Youth Services; Section 2.A; Standard 10.

STANDARD 6: The organization participates in inter-organizational interdisciplinary or transdisciplinary collaboration, in order to facilitate the coordination of services and improve child and family outcomes.

Competencies

- Knowledge of federal, provincial, and local organizations and resources to support coordinated service delivery.
- Ability to function effectively and cooperatively as a team member, communicator and consultant.
- Ability to identify team members' skills and knowledge, and use these to inform service planning and delivery.
- Possession of interpersonal and problem-solving skills that promote effective team participation.
- Ability to organize team meetings, negotiate team member roles, delegate responsibilities, and facilitate team goals.
- Understanding of, and respect for, each team member's role and contribution.
- Ability to collaboratively support, educate, and train caregivers and other professionals who work with the child.

Demonstration of Competencies

- Develop and maintain strong, positive relationships with a wide range of organizations and community resources.
- Contribute to inter-organizational and community development activities.
- Establish a clearly documented plan that defines the purpose of the early intervention team's work and each member's responsibilities, and identifies the person with primary responsibility for service coordination (adapted from Townsley et al., 2004).
- Demonstrate inter- and intra-organizational communication to meet the needs of the child and family across multiple environments and contexts.

Definition

- Inter-organizational collaboration refers to collaboration among service providers and community partners from multiple organizations.
- Intra-organizational collaboration refers to collaboration among service providers from a single organization.
- For more information on the interdisciplinary and transdisciplinary approaches, see Early Intervention Therapy Team Approach on page 7.

Links

- CARF: Medical Rehabilitation; Section 3.F; Standard 18.
- CARF: Child and Youth Services; Section 2.B; Standard 11.

STANDARD 7: The organization integrates clinical expertise with current research evidence to improve outcomes for children and families.

Competencies

- Ability to synthesize evaluation data, relevant evidence, clinical expertise, professional consensus, and child and family preferences to inform the development of an intervention plan for the child and family.
- Knowledge of evidence-based paediatric assessment tools and intervention methods.

Demonstration of Competencies

- Provide recommendations that are based on a combination of research evidence, clinical expertise, and consideration of the family's particular situation.
- Continually expand professional knowledge base through ongoing education and the critical evaluation of emerging research and professional literature.
- Communicate with other intervention and health professionals in order to learn of emerging professional consensus.

Links

- CARF: Child and Youth Services; Section 2.B; 2.

STANDARD 8: The organization provides services in settings that emphasize relevance and comfort for the child and family, and at times of the day that are mutually convenient for the child, family and service provider.

Competencies

- Understanding of the role of environmental factors on childhood development and participation.
- Ability to identify, and incorporate into services, a full range of settings in which the child and family function.
- Understanding that a 'clinic' setting, such as a hospital or child development centre, may be an appropriate setting for some children in certain situations (Jackson, 2006).
- Flexibility in the scheduling of services.

Demonstration of Competencies

- Incorporate therapy goals and interventions into everyday routines and activities.
- Provide services in settings that are accessible and comfortable for the child and family. This may include the home, or child care, preschool and other community settings.
- Provide services at the times of day that are mutually convenient for the child, family, and service provider.

Links

- CARF: Child and Youth Services; Section 2.B; Standard 5.
- COA: PA-CFD; Standards 13.04 and 13.06 (a, d, and e).

STANDARD 9: The organization considers the community's unique situation and promotes accessible, inclusive environments so that children and families are able to fully participate in community life.

Competencies

- Recognition that children and families exist within the context of their communities.
- Ability to support child and family involvement in meaningful life situations and promote supportive communities.
- Understanding of the potential value of sources of support other than formal professional services.
- Knowledge of existing community-based services and supports.

Demonstration of Competencies

- Provide information about inclusion to the family and support their efforts to advocate for their child's inclusion.
- Identify, and integrate Early Intervention Therapy services into, existing community-based services and supports in order to foster community development.
- Advocate for needed community services when they are lacking or not easily accessible, and become involved in their development.
- Build relationships with community resources by:
  - participating in outreach and information sharing at community forums; and
  - coordinating resources and planning professional development activities with other professionals and organizations.
- Encourage the development of the community's capacity to support the inclusion and participation of children with special needs and their families by:
  - advocating for accessible environments and supportive community attitudes (King, 2003);
  - demonstrating how the child can be included in existing programs and settings;
  - enabling families to advocate on their own behalf;
  - sharing information regarding community resources with families;
  - facilitating contacts between families and community resources; and
  - offering to teach caregiver and child development classes.

Links

CARF: Medical Rehabilitation; Section 3.F; Standards 4 (a) and 19.

- CARF: Child and Youth Services; Section 2.A; Standards 6 (b) and 9.
- CARF: Child and Youth Services; Section 3.C; Standard 1.
- COA: PA-CFD; Standard 13.07.

STANDARD 10: The organization establishes a team of competent and qualified staff who maintain and expand their competencies through continuous learning and self-appraisals. The team includes an occupational therapist, physiotherapist, and speech-language pathologist, and may also include a family support professional.

Competencies

- Knowledge regarding the care of children with special needs and their families.
- Understanding of children's developmental needs.
- Familiarity with the methods for developing a supportive learning environment that is responsive to the child and family's needs.
- Knowledge of therapeutic techniques, including those that are specific to paediatric practice.[10]
- Ability to analyze problems systematically and generate solutions (adapted from BC Public Service Agency, n.d).
- Ability to work effectively within a variety of situations and with diverse individuals or groups (BC Public Service Agency, n.d).
- Ability to provide training and supervision to direct support personnel, therapy students, and/or therapy assistants.
- Ability to identify community and provincial resources that support children's optimal health and development.

Demonstration of Competencies

- Meet the requirements of the relevant professional self-regulatory body.
- Adhere to the Code of Ethics of the relevant professional self-regulatory body.
- Maintain and expand skills through regular, ongoing education and self-appraisals (Noyes-Grosser et al., 2005).
- Adapt service delivery approaches to accommodate changing situations and perspectives.

Links

- CARF: Medical Rehabilitation; Section 3.F; Standard 7.
- CARF: Child and Youth Services; Section 2.B; Standard 6.
- CARF: Child and Youth Services; Section 3.C; Standard 2.

10 This competency applies specifically to occupational therapists, physiotherapists, and speech-language pathologists.

STANDARD 11: The organization implements waitlist and caseload prioritization and management strategies that include:

- preliminary determination of the child and family's service needs prior to their placement on a waitlist;
- identification of interim resources that may be appropriate while the child is on a waitlist; and
- provision of information to families regarding the expected waiting time.

Competencies

- Knowledge of, and ability to effectively implement, the organization's waitlist and caseload prioritization and management strategies.
- Understanding of research evidence related to workload management. For more information, see Program Resources on page 30.

Demonstration of Competencies

- Adhere to the organization's established waitlist and caseload prioritization and management strategies.

Links

- CARF: Child and Youth Services; Section 2.C; Standard 5.
- COA: PA-CFD; Standard 2.03.

STANDARD 12: The organization engages in continuous quality improvement.

Competencies

- Knowledge of, and ability to apply, outcome measures and program evaluation methods.
- Ability to use information from program evaluations to modify services as needed.

Demonstration of Competencies

- Participate in regular program evaluations that measure the appropriateness, efficacy, responsiveness, and individualization of services.
- Maintain and enhance knowledge of quality assurance processes, including outcome measurement and program evaluations, through ongoing education and the critical evaluation of research and professional literature.

Links

- COA: CA-PQI; Standard 1.03.
- For more information on quality assurance processes, see Accountability and Quality Assurance on page 28.

HEALTH PROFESSIONS ACT AND REGULATORY BODY REGISTRATION

Self-regulatory bodies are delegated the authority to govern the professional practice of their members under the Health Professions Act, available at the Queen's Printer website, *www.qp.gov.bc.ca/statreg/stat/H/96183_01.htm*. Self-regulatory bodies serve and protect the public by ensuring that services are provided in a safe, ethical, and competent manner.

Early Intervention Therapy (EIT) services must be delivered in accordance with the professional practice guidelines and standards of the relevant self-regulatory body. Professional practice guidelines and standards focus on a particular profession and the clinical competencies required to provide services.

Occupational therapists practicing in British Columbia must be registered with the College of Occupational Therapists of British Columbia. For more information, visit *www.cotbc.org/* or *www.healthservices.gov.bc.ca/leg/notice/occupational_therapy.html*.

Physiotherapists practicing in British Columbia must be registered with the College of Physical Therapists of British Columbia. For more information, visit *www.cptbc.org* or *www.healthservices.gov.bc.ca/leg/notice/physical_therapy.html*.

The College of Speech and Hearing Health Professionals of British Columbia will be fully responsible for regulating the professional practice of speech-language pathologists, audiologists, and hearing aid dispensers as of April 1, 2010. For more information, visit *www.healthservices.gov.bc.ca/leg/notice/speech_and_hearing_health_professionals.html*.

Currently, speech-language pathologists providing EIT services must be registered with either the British Columbia Association of Speech-Language Pathologists and Audiologists or the Canadian Association of Speech-Language Pathologists and Audiologists, though this is not a requirement for practice in British Columbia. For more information, visit *www.bcaslpa.ca/* or *www.caslpa.ca/*. As of April 1, 2010, speech-language pathologists providing EIT services must be registered with the College of Speech and Hearing Health Professionals of British Columbia.

Family support is currently an unregulated profession in British Columbia. Social workers providing EIT family support services may register with the Board of Registration for Social Workers, though this is not currently a requirement for practice. For more information, visit *www.brsw.bc.ca*. A revised Social Workers Act will come into force at a date to be announced and establish a College of Social Workers.

Clinical counsellors providing EIT family support services may register with the British Columbia Association of Clinical Counsellors, though this is not a requirement for practice. For more information, visit *www.bc-counsellors.org/*.

Accountability and Quality Assurance

Quality assurance processes should be regularly undertaken by qualified personnel. This section describes two types of quality assurance processes: accreditation and program evaluation. Organizations delivering Early Intervention Therapy (EIT) services are also responsible for reporting on indicators, as defined in each organization's contract with the Ministry of Children and Family Development.

ACCREDITATION

Organizations that are accredited by the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or the Canadian Council on Health Services Accreditation are responsible for conducting regular program evaluations, as stipulated by their respective accrediting body. For more information on accreditation, see Program Resources on page 30.

PROGRAM EVALUATION

Evaluations can vary in scope and purpose, and may incorporate output and outcome information, with the results generalized to the program in order to improve practices for children and families. A comprehensive evaluation should consider functional child gains related to social, communication, mobility and adaptive skill development, as well as the improvement of family function (Bennett and Guralnick, 1991). It is particularly important to evaluate the appropriateness, efficacy, responsiveness, and individualization of services, and involve families in evaluating outcomes in order to determine whether services resulted in effective, meaningful change (Fuchs and Hungerford 2005). Guralnick (2001) notes that a strong evaluative component is essential in order to determine the child's progress towards meeting established outcomes and modify services accordingly.

The effectiveness of EIT services may be evaluated with a variety of tools. The following are examples of validated program evaluation tools that may be useful for both accredited and non-accredited organizations. The program logic model on page 40 should also be referred to, as it outlines the intended program outcomes.

Individualized Family Service Plan

The Individualized Family Service Plan, or equivalent planning document, provides a useful baseline for determination of the extent to which outcomes have been achieved. It is recommended that the planning document be reviewed every six months, involving an evaluation of the family's satisfaction with services, the effectiveness of intervention processes, and documentation of outcomes (Fuchs and Hungerford, 2005).

Measure of Processes of Care

The Measure of Processes of Care (MPOC) is a fifty-six item questionnaire used to assess caregivers' perceptions of the extent to which services are family-centred. It is based on the following categories:

- Enabling and Partnership;
- Providing General Information;
- Providing Specific Information About the Child;
- Coordinated and Comprehensive Care for the Child and Family; and
- Respectful and Supportive Care.

The MPOC –Service Provider (MPOC-SP) measures professionals' perceptions of care in the same categories, thus permitting comparisons of caregivers' and professionals' responses. Although studies have confirmed the reliability and validity of MPOC and MPOC-SP (CanChild Centre for Childhood Disability Research, 2007), these tools only measure one element of program effectiveness and are therefore recommended for the evaluation of intervention services only in conjunction with other methods (Fuchs and Hungerford, 2005).

The MPOC and MPOC-SP may be accessed at *www.canchild.ca* .

Goal Attainment Scaling

Goal Attainment Scaling (GAS) measures individual developmental progress over five potential levels of achievement. The expected outcome is stated in the middle level, with two levels each above and below it. The child and family should be involved in setting goals at each level, in order to ensure that they are realistic and relevant (Cox and Amsters, 2002).

The reliability and validity of GAS may be enhanced through comprehensive training of goal raters, the use of multiple raters, and a clear definition of each level of goal attainment. In order to provide a comprehensive assessment, it is suggested that criterion-referenced measures such as GAS be used in conjunction with valid standardized measures (King et al, 1999).

Program Resources

The information below is intended to provide organizations with resources that may assist in the planning and delivery of Early Intervention Therapy (EIT) services. Clinical and professional practice resources are available through self-regulatory bodies and professional associations.

BUSINESS PRACTICE

Accreditation

An organization delivering EIT services must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA), if the combined value of its contracts with the Ministry of Children and Family Development exceeds $500,000. Please note that this stipulation does not apply to organizations operating as part of a health authority, as these organizations must be accredited by the Canadian Council on Health Services Accreditation (CCHSA).

Accreditation under CARF, COA, or CCHSA represents a commitment to a high standard of service delivery and a focus on continuous quality improvement to meet the needs of children and families. For more information, visit:

- CARF: *www.carf.org*
- COA: *www.coanet.org*
- CCHSA: *www.cchsa.ca*

Confidentiality

In accordance with the relevant accrediting body, policies respecting the confidentiality of children and families' information should be present. Information regarding children or families must be stored and shared in compliance with the *Freedom of Information and Protection of Privacy Act* and other relevant legislation. For more information, visit *www.qp.gov.bc.ca/statreg/reg/F/323_93.htm*.

Complaints Processes

Families or professionals may have concerns or complaints about services received and/or the actions of professionals. These may be directed to:

- The individual or organization providing the service.
- The Ministry of Children and Family Development. For more information, visit *www.mcf.gov.bc.ca/complaints/index.htm* or contact your region's Professional Services Manager/Complaint Resolution Manager. Contact information is available at *www.mcf.gov.bc.ca/complaints/quality_assurance.htm*.
- The relevant self-regulatory body or professional association. Self-regulatory bodies have the authority to review and investigate complaints regarding the practices of their members. For more information, visit:
  - Board of Registration of Social Workers: *www.brsw.bc.ca*
  - British Columbia Association of Clinical Counsellors: *www.bc-counsellors.org/*
  - British Columbia Association of Speech-Language Pathologists and Audiologists: *www.bcaslpa.ca/*
  - Canadian Association of Speech-Language Pathologists and Audiologists: *www.caslpa.ca/*
  - College of Occupational Therapists of British Columbia: *www.cotbc.org*
  - College of Physical Therapists of British Columbia: *www.cptbc.org*
- Representative for Children and Youth

- This independent office of the Legislature aims to improve services and outcomes for children through advocacy, accountability and review of public agencies. Information regarding applicable rights, policies and complaint processes may be available. For more information, visit *www.rcybc.ca*.
- Office of the Ombudsman: *www.ombud.gov.bc.ca*. The Office of the Ombudsman receives inquiries and complaints regarding the practices and services provided by public bodies, and may investigate to determine whether the public body is being fair to the people it serves.

CHILD WELFARE

In accordance with the ***Child, Family and Community Service Act***, anyone who has concerns about a child's safety or well-being has a legal obligation to promptly report their concerns to a child welfare worker. For more information, visit *www.qp.gov.bc.ca/statreg/stat/C/96046_01.htm.*

EVIDENCE-BASED PRACTICE AND RESEARCH

Canadian Institute of Health Research (Institute of Human Development, Child and Youth Health
The Canadian Institute of Health Research (CIHR) is a federally-funded initiative aimed at creating new knowledge and translating it into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system. CIHR's Institute of Human Development, Child and Youth Health supports research related to early childhood development and other topics. For more information, visit *www.cihr-irsc.gc.ca/e/8695.html*.

CanChild
Research programs at CanChild concentrate on children and youth with disabilities and their families within the context of their communities. For more information, visit *www.canchild.ca/* .

Centre of Excellence for Children & Adolescents with Special Needs
This Centre is located at Lakehead University in Thunder Bay, Ontario and includes the following partners: Memorial University, Mount St. Vincent University, University of Northern British Columbia and the Government of Nunavut. The Centre is committed to ensuring that young people with special needs living in rural and northern communities receive the best services Canada has to offer. For more information, visit *www.coespecialneeds.ca/* .

Child Development and Rehabilitation Website
A joint project of *Sunny Hill Health Centre for Children* and the Ministry of Children and Family Development, this web site contains child development and rehabilitation resources. For more information, visit *www.childdevelopment.ca/* .

Sunny Hill Health Centre for Children
Sunny Hill Health Centre for Children is an academic health facility that works with a network of research partners to develop new knowledge and technologies aimed at enhancing the healthy development of children with disabilities and their families. For more information, visit *www.bcchildrens.ca/Services/SunnyHillHealthCtr/Research/default.htm.*

PROGRAM EVALUATION

Canadian Institute for Health Information
The Canadian Institute for Health Information (CIHI) is an independent, non-profit organization that provides essential data and analysis on Canada's health system and the health of Canadians. CIHI's data and reports focus on: health care services, health spending, health human resources and population health. For more information, visit *http://secure.cihi.ca/cihiweb/.*

Canadian Outcomes Research Institute
The Canadian Outcomes Research Institute (CORI) is a non-profit organization with an educational and research oriented mandate. CORI aims to increase the effectiveness of human service

organizations to meet the needs of those served by providing education, research, training, and services regarding outcomes and evidence-based practice. For more information, visit *www.cori.ca.*

Early Childhood Outcomes Center
The Early Childhood Outcomes Center conducts research and provides resources to promote the development and implementation of child and family outcome measures for infants, toddlers and preschoolers with disabilities. For more information, visit *www.fpg.unc.edu/~ECO/*.

International Classification of Functioning, Disability and Health
The International Classification of Functioning, Disability and Health (ICF) is the World Health Organization's framework for measuring health and disability at both individual and population levels. For more information, visit *www.who.int/classifications/icf/en/*.

United Way Outcome Measurement Resource Network
United Way is a national network of more than 1,300 locally governed organizations that work to create lasting positive changes in communities and peoples' lives. United Way's program outcome measurement resources are available at *http://national.unitedway.org/outcomes/library/pgmomres1.cfm.*

SERVICE DELIVERY

Resources to Support Collaborative Practice

Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative
The EICP Steering Committee developed principles and a framework to encourage and enhance interdisciplinary collaboration in primary health care in Canada, as well as a collaboration toolkit to support interdisciplinary practice. For more information, visit the EICP website at *www.eicp.ca*

Canadian Nurse Practitioner Initiative (CNPI), Questions and Answers: Collaborative Practice
The CNPI provides information regarding the benefits and challenges of implementing collaborative practice in health care settings and the elements needed to support successful collaboration. For more information, visit *www.cnpi.ca/documents/pdf/Q_A_practice_2005_e.pdf*.

Resources to Support Meaningful and Culturally Safe Services for Aboriginal Communities

The *British Columbia Aboriginal Child Care Society* is a non-profit organization serving Aboriginal early childhood programs throughout British Columbia. Publications available at its website, *www.acc-society.bc.ca/files_new/resources.html*, include:

- ***A Guide for Culturally-Focused Early Intervention Therapy Programs for Aboriginal Children and Families in British Columbia.*** This guide provides Aboriginal communities with information about early intervention therapies to assist families in accessing these services, advocating for funding of early intervention therapy services, and partnering with early intervention therapists.
- ***Steps in the Right Direction: Connecting and Collaborating with Aboriginal Communities in the Delivery of Early Intervention Therapy Services.*** This resource provides information on supporting the design and delivery of early intervention programs in Aboriginal communities that are meaningful, effective and culturally safe.

Individualized Family Service Planning

National Early Childhood Technical Assistance Centre (NECTAC) provides resources on writing outcomes, as well as planning and implementing an Individualized Family Service Plan (IFSP). These are available on NECTAC's IFSP Process: Planning and Implementing Family-Centered Services in Natural Environments web page at *www.nectac.org/topics/families/ifspprocess.asp*

See Appendix C: A Sample Individualized Family Service Plan Template on page 44.

Promoting Manageable Workloads

The Office of the Provincial Paediatric Therapy Consultant has commissioned a Promoting Manageable Workloads Project, which will include recommended guidelines regarding caseload and waitlist management for paediatric therapists. For more information, visit *www.therapybc.ca*.

Utilization of Therapist Assistants

Information on the use of therapist assistants is provided in Researching the Role of Rehabilitation Assistants in a Pediatric Settings in British Columbia. The following companion guides are intended to support the effective use of therapist assistants:

- Employer's Guide to Hiring a Therapist Assistant
- Frequently Asked Questions Regarding the use of Therapist Assistants in Paediatric Settings
- Sample Tasks and Activities Performed by Therapist Assistants in Paediatric Settings

These documents can be found on the *TherapyBC* web site at *www.therapybc.ca*.

SPECIALIZED PROVINCIAL SERVICES

The Provincial Health Services Authority (PHSA) manages province-wide programs and services, including:

- BC Autism Assessment Network;
- Complex Developmental Behavioural Conditions Network; and
- programs and services available through Sunny Hill Health Centre for Children.

BC Autism Assessment Network

The BC Autism Assessment Network (BCAAN) provides assessment and diagnosis services for children and youth who may have Autism Spectrum Disorder. Services are provided by specialists and health care professionals throughout British Columbia. For more information, including BCAAN contact information for each region, visit *www.phsa.ca/AgenciesServices/Services/Autism/default.htm.*

Complex Developmental Behavioural Conditions Network

Regional health authorities, in partnership with the Provincial Health Services Authority, provide multidisciplinary assessment services for children and youth with complex developmental behavioural conditions, including children and youth who may have Fetal Alcohol Spectrum Disorder. This Complex Developmental Behavioural Conditions (CDBC) Network offers assessment services for children and youth who have significant difficulties in multiple areas of function including development and learning, mental health, and adaptive and social skills. For more information, including CDBC Network contact information for each region, visit *www.mcf.gov.bc.ca/fasd/assessment.htm.*

Sunny Hill Health Centre for Children

Sunny Hill Health Centre for Children offers provincial outreach services for children and youth with complex disabilities, their families, and community professionals throughout British Columbia. Services include:

- prescription and fitting of customized assistive devices;
- complex feeding and nutritional assessment; and
- psychology assessment or consultation.

Sunny Hill Health Centre for Children also offers professional support services for community-based therapists to develop and increase their skills and knowledge. Services include co-assessments, workshops, and video-conferencing. For more information, visit *www.bcchildrens.ca/Services/SunnyHillHealthCtr/default.htm.*

STUDENT FIELDWORK RESOURCES

University of British Columbia Therapy Fieldwork Coordinators:

Department of Occupational Science and Occupational Therapy
T-325, 2211 Westbrook Mall
Vancouver, BC V6T 2B5
Telephone: (604) 822-7392
Fax: (604) 822-7624

Department of Physical Therapy
T-325, 2211 Westbrook Mall
Vancouver, BC V6T 2B5
Telephone: (604) 822-7392
Fax: (604) 822-7624

School of Audiology and Speech Sciences
J.M. Mather Building
5804 Fairview Avenue
Vancouver, BC V6T 1Z3
Telephone: (604) 822-5591
Fax: (604) 822-5591

TRANSITION TO SCHOOL

The Ministry of Education has a number of Provincial Resource Programs that are designed to assist school districts in British Columbia to meet the educational needs of students with special needs. The following is a list of some Provincial Resource Programs:

- *Provincial Resource Centre for the Visually Impaired*
- *Provincial Outreach Program for Autism and Related Disorders*
- *Provincial Outreach Program for Students with DeafBlindness*
- *Provincial Integration Support Program*
- *Special Education Technology British Columbia* (SET-BC)

For a complete list of Provincial Resource Programs, see the Ministry of Education's *Special Education Services: A Manual of Policies, Procedures and Guidelines*, which is available at *www.bced.gov.bc.ca/*.

Bibliography

Accreditation Council for Canadian Physiotherapy Academic Programs et al. (2004). ***Essential Competency Profile for Physiotherapists in Canada***. Obtained August 27, 2007 from ***http://www.collegept.org/college/content/pdf/en/guide07/III.A.2.Essentail_Competency_Profile.pdf***

American Association of Intellectual and Developmental Disabilities (2007a). ***Position Statement on Direct Support.*** Retrieved January 16, 2007 from ***http://www.aamr.org/Policies/pos_early_intervention.shtml***

American Association of Intellectual and Developmental Disabilities (2007b). ***Position Statement on Early Intervention***. Retrieved January 16, 2007 from ***http://www.aamr.org/Policies/pos_early_intervention.shtml***

American Association of Intellectual and Developmental Disabilities (2007c). ***Position Statement on Service Delivery***. Retrieved January 16, 2007 from ***http://www.aamr.org/Policies/pos_early_intervention.shtml***

American Association of Intellectual and Developmental Disabilities (2007d). ***Position Statement on Waiting Lists.*** Retrieved January 16, 2007 from ***http://www.aamr.org/Policies/pos_early_intervention.shtml***

American Occupational Therapy Association, Inc. (2006). ***AOTA Pediatric Board Certification Competencies and Indicators***.

Australian Institute of Health and Welfare (2002). ***Disability Data Briefing: The International Classification of Functioning, Disability and Health (ICF)***. 20

BC Ministry of Advanced Education (2004). ***Child Care Sector Occupational Competencies Assessment Tool***.

BC Ministry of Children and Family Development (2006). ***Children and Youth with Special Needs: A Glossary of Terms – Version One***.

BC Ministry of Children and Family Development (2007). ***Draft EIBI Clinical Standards***.

BC Ministry of Health and the Ministry Responsible for Seniors (1995). ***Program Guidelines: Early Intervention Program***.

BC Ministry of Health Planning (2002). ***Provincial Health Officer's Annual Report 2001: The Health and Well-Being of Aboriginal People in British Columbia.*** Retrieved July 10, 2007 from ***http://www.healthservices.gov.bc.ca/pho/pdf/phoannual2001.pdf***

BC Public Service Agency (n.d). ***BC Public Service Competency Dictionary***. Retrieved November 15, 2007 from ***http://www.bcpublicservice.ca/down/pdfs/competency_dictionary.pdf***

Bennett, F.C. and Guralnick, M.J. (1991). Effectiveness of Developmental Intervention in the First Five Years of Life. ***Development and Behavior: The Very Young Child***; 38(6): 1513-1528.

Block, A.W., and Block, S.R (2002). Strengthening Social Work Approaches Through Advancing Knowledge of Early Childhood Intervention. ***Child and Adolescent Social Work Journal***; 19(3), 191-208.

Bornman, J. (2004). The World Health Organisation's Terminology and Classification: Application to Severe Disability. ***Disability and Rehabilitation;*** 26(3):182-188

Cahill, J. (1996). Patient Participation: A Concept Analysis. ***Journal of Advanced Nursing***, 24, 561-571.

Canadian Council on Health Services Accreditation (2008). Retrieved July 15th, 2008 from ***http://www.cchsa.ca/***

CanChild Centre for Childhood Disability Research (2007). ***Measure of Processes Care (MPOC)***. Retrieved January 26, 2007 from http://www.canchild.ca/Default.aspx?tabid=200

Child, Family and Community Service Act (1996). Retrieved July 5th, 2007 from ***http://www.qp.gov.bc.ca/statreg/stat/C/96046_01.htm***

Coaching in Early Childhood (2006). ***Coaching Practices – Coaching in Early Childhood***. Retrieved April 25th, 2007 from ***http://www.coachinginearlychildhood.org/ccoaching.php***

Commission on Accreditation of Rehabilitation Facilities (2007). CARF 2007 Standards Manual. Retrieved July 5th, 2007 from ***http://www.carf.org/***

Cook, R. (1996). Paths to Effective Teamwork in Primary Care Settings. ***Nursing Times,*** 92(14), 44-45.

Council on Accreditation (2007). Service Standards. Retrieved July 5th, 2007 from ***http://www.coanet.org***

Cox, R. and Amsters, D. (2002). Goal Attainment Scaling: An Effective Outcome Measure for Rural and Remote Health Services. ***Australian Journal of Rural Health***; 10: 256-261.

Cusick, A., McIntyre, S., Novak, I., Lannin, N. and Lowe K. (2006). A Comparison of Goal Attainment Scaling and the Canadian Occupational Performance Measure for Paediatric Rehabilitation Research. ***Pediatric Rehabilitation***; 9(2): 149-157.

den Heyer, I. and Kienapple, K. (2005). ***Enhancing Personnel Preparation for Early Intervention in Nova Scotia.*** Early Intervention Task Force: Mount Saint Vincent University, Centre of Excellence for Children & Adolescents with Special Needs Lakehead University. Retrieved June 29, 2007 from ***http://www.coespecialneeds.ca***

Department of Justice (1982). ***The Constitution Act, 1982***. Retrieved July 10, 2007 from ***http://laws.justice.gc.ca/en/const/annex_e.html#II***

ECIP Saskatchewan Inc. (2006). ***Saskatchewan Early Childhood Intervention Programs Standards and Guidelines.***

Enderby, P. (2002). Teamworking in Community Rehabilitation. ***Journal of Clinical Nursing,*** 11, 409-411.

Enhancing Interdisciplinary Collaboration in Primary Health Care (March 2006). ***The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care***. Retrieved December 7th, 2006 from ***http://www.eicp-acis.ca/en/***

Freedom of Information and Protection of Privacy Act (2003). Retrieved July 5th, 2007 from ***http://www.qp.gov.bc.ca/statreg/reg/F/323_93.htm***

Freund, P.J., Boone, H.A., Barlow, J.H. and Lim, Chih Ing (2005). Healthcare and Early Intervention Collaborative Supports for Families and Young Children. ***Infants & Young Children***; 18(1): 25-36.

Fuchs, T. and Hungerford, M. (2005). The Evaluation of Early Childhood Intervention Service Delivery: Proposed Evaluation Framework and Final Report. ***British Columbia Association for Child Development and Intervention***.

Gerlach, A. (2007). ***Steps in the Right Direction: Connecting & Collaborating in Early Intervention Therapy with Aboriginal Families & Communities in British Columbia.*** British Columbia Aboriginal Child Care Society.

Greco, V., Sloper, P., Webb, R. and Beechmam, J. (2006). Key Worker Services for Disabled Children: The Views of Staff. ***Health and Social Care in the Community***; 14(6): 445-452.

Guralnick, M.J. (2001). A Developmental Systems Model for Early Intervention. ***Infants & Young Children***; 14(2): 1-18.

Hanft, B.E. and Feinberg, E. (1997). Toward the Development of a Framework for Determining the Frequency and Intensity of Early Intervention Services. ***Infants & Young Children***; 10(1): 27-37.

Health Professions Act (1996). Retrieved July 5th, 2007 from ***http://www.qp.gov.bc.ca/statreg/stat/H/96183_01.htm***

Indiana First Steps Program (2004). ***Best Practices in Early Intervention***. Retrieved November 20th, 2006 from ***http://www.in.gov/fssa/first_step/pdf/BestPracticeFINAL1-04.pdf***

Ingersoll, G. L., & Shmitt, M. (2003). ***Appendix B Interdisciplinary Collaboration, Team Functioning, and Patient Safety***. Rochester: University of Rochester Medical Centre.

Iversen, M.D., Shimmel, J.P., Cicerra, S.L. and Prabhakar, M. (2003). Creating a Family-Centred Approach to Early Intervention Services: Perceptions of Families and Professionals. ***Pediatric Physical Therapy***; 15(1):23-31.

Jackson, L (2006). Transdisciplinary Teams and the Scope of OT. ***OT Practice – American Occupational Therapy Association***; 11(6): 15.

Kertoy, M., Killip, m., Miller, L., Hatherell, A., and Korzenieki, T. (2006). Smooth Transition to Junior Kindergarten: Influential Factors and Outcomes of a Family Program to Prepare Children for School. ***Research Alliance for Children with Special Needs***; 6(1).

King, G (2003). "Best Approaches" in Pediatric Rehabilitation: Intervention Principles For Service Providers. ***Research Alliance for Children with Special Needs***; 6(1).

King, G. et al. (2002). Family-Centred Service in Ontario: A "Best Practice" Approach for Children with Disabilities and Their Families. ***In Brief (#02-01), CanChild Centre for Childhood Disability Research, McMaster University***. Retrieved from *http://www.canchild.ca/*

King, G. et al. (1999). Goal Attainment Scaling: Its Use in Evaluating Pediatric Therapy Program. ***Physical & Occupational Therapy in Pediatrics***; 19(2): 31-52.

King, G. et al. (2002). A Life Needs Model of Pediatric Service Delivery: Services to Support Community Participation and Quality of Life for Children and Youth with Disabilities. ***Physical & Occupational Therapy in Pediatrics;*** 22(2):53-77.

King, G. et al. (2006). Bringing the Life Needs Model to Life: Implementing a Service Delivery Model for Pediatric Rehabilitation. ***Physical & Occupational Therapy in Pediatrics;*** 26(1/2):43-70.

Kontos, S., and Diamond, K. (2002). Measuring the Quality of Early Intervention Services for Infants and Toddlers: Problems and Prospects. ***International Journal of Disability,Development and Education***; 49(4), 337-351.

Landsman, G.H. (2005). What Evidence, Whose Evidence? Physical Therapy in New York State's Clinical Practice Guidelines and in the Lives of Mothers of Disabled Children. ***Social Science & Medicine***; 62(2006): 2670-2680.

Law, M. (2000). Strategies for Implementing Evidence-Based Practice in Early Intervention. ***Infants & Young Children***; 13(2): 32-40.

Law, M., Rosenbaum, P., Jaffer, S., Plews, N., Kertoy, M. and King, S. (2004). Service Coordination for Children and Youth with Complex Needs. ***CanChild Centre for Childhood Disability Research, McMaster University.***

MacQueen, K. et al. (2001). What is Community? An Evidence-Based Definition for Participatory Public Health. ***American Journal of Public Health***, 91 (12): 1929-1938. Retrieved August 17th, 2007 from *http://www.ajph.org/cgi/content/abstract/91/12/1929*

Malone, D.M. et al. (2000). Social Work Early Intervention for Young Children with Developmental Disabilities. ***Health & Social Work***; 25(3): 169-180.

McLaren, C. and Rodger, S. (2003). Goal Attainment Scaling: Clinical Implications for Paediatric Occupational Therapy Practice. ***Australian Occupational Therapy Journal – Australian Association of Occupational Therapists***; 216-224.

Mukherjee at al. (2006). A Resource Pack: Developing a Key Worker Services for Families with a Disabled Child. ***Care Co-ordination Network UK Social Policy Research Unit.***

Nisga'a Final Agreement (1999). Retrieved July 5th, 2007 from *http://www.ainc-inac.gc.ca/pr/agr/nsga/nisdex_e.html*

Noyes-Grosser, D.M. et al. (2005). Rationale and Methodology for Developing Guidelines for Early Intervention Services for Young Children with Developmental Disabilities. ***Infants & Young Children***; 18(2): 119-135.

Palisano, R.J. (1993). Validity of Goal Attainment Scaling in Infants with Motor Delays. ***Physical Therapy***; 73(10).

Pilkington, K.O. (2006). Side by Side: Transdisciplinary Early Intervention in Natural Environments. ***OT Practice – American Occupational Therapy Association***; 11(6): 12-17.

Polivka, B.J., Howard Dresbach, S., Heimlich, J.E. and Elliot, M. (2001). Interagency Relationships among Rural Early Intervention Collaboratives. ***Public Health Nursing***; 18(5), 340-349.

Rapport, M.J., et al. (2004). Practices Across Disciplines in Early Intervention: The Research Base. ***Infants and Young Children; 17(1): 32-44.***

Representative for Children and Youth and Office of the Provincial Health Officer (2007). Joint Special Report Health and Well-Being of Children in Care in British Columbia: Educational Experience and Outcomes. Retrieved September 2nd, 2008 from *http://www.health.gov.bc.ca/pho/pdf/joint_special_report.pdf*.

Romanczyk, R.G., Gillis, J.M., Noyes-Grosser, D.M., Holland, J.P., Holland, C.L. and Lyons, D. (2005). Clinical Clues, Developmental Milestones, and Early Identification/Assessment of Children with Disabilities. ***Infants & Young Children;*** 18(3): 212-221.

Sandall, S., McLean, M.E. and Smith, B.J. (2000). DEC Recommended Practices in Early Intervention/Early Childhood Special Education. Reston, Virginia: ***Council for Exceptional Children, Division for Early Childhood***.

School Act (1996). Retrieved October 12th, 2007 from ***http://www.qp.gov.bc.ca/statreg/stat/S/96412_00.htm***

Shannon, P. (2004). Barriers to Family-Centred Services for Infants and Toddlers with Developmental Delays. ***Social Work***; 49(2): 301-308.

Smith, B. (2000). Administrator's Essentials: Creating Policies and Procedures that Support Recommended Practices in Early Intervention/Early Childhood Special Education (EI/ECSE). ***DEC Recommended Practices in Early Intervention/Early Childhood Special Education***; 125-134.

Soever, L. (2006). ***Primary Health Care and Physical Therapists – Moving the Profession's Agenda Forward***. Retrieved July 5th, 2007 from ***http://www.cpta.ab.ca/resources/publications_primaryhealthcare.pdf***

Stepans et al. (2002). The Role of the Nurse on a Transdisciplinary Early Intervention Assessment Team. ***Public Health Nursing;*** 19(4):238-245.

Stewart, D., Law, M., Russell, D. and Hanna, S. (2004). Evaluating Children's Rehabilitation Services: An Application of a Programme Logic Model. ***Child: Care, Health & Development***; 30(5): 453-462.

Tennessee's Early Intervention System (2001). ***Guidelines for Communication – Eligibility Determination***. Retrieved November 8th, 2006 from ***http://www.state.tn.us/education/speced/TEIS/pdfs/Communication%20Guidelines.pdf***

Townsley et al. (2004). ***Making a Difference? Exploring the Impact of Multi-Agency Working on Disabled Children with Complex Health Care Needs, Their Families and the Professionals who Support Them.*** Bristol, UK: The Policy Press, University of Bristol.

Tufts Managed Care Institute (2000). ***Population-Based Health Care: Definitions and Applications***. Retrieved July 11, 2007 from ***http://www.tmci.org/downloads/topic11_00.PDF***

United Nations (1990). ***Convention on the Rights of the Child***. Retrieved July 5th, 2007 from ***http://www.unhchr.ch/html/menu3/b/k2crc.htm***

United Nations (2007). ***Convention on the Rights of Persons with Disabilities***. Retrieved July 5th, 2007 from ***http://www.un.org/esa/socdev/enable/rights/convtexte.htm***

World Health Organization (2001). ***International Classification of Functioning, Disability and Health: ICF.*** Geneva: World Health Organization

Appendix A: Early Intervention Therapy Program Logic Model

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
			Immediate	Intermediate	Ultimate
Target Population Children birth to school entry who are at risk of, or who have, a suspected or identified delay and/or disability. **Funding (MCFD)** **Professional Staff** OT, PT, SLP, and family support professionals or social workers **Research & Evidence-Based Practice** **Professional practice guidelines**	*Therapy Services* • Screening • Assessment • Therapy-related consultations • Direct and group therapy • Equipment prescription, loan and adaptation • Monitoring of child and delegated tasks	• Screening services • Assessments • Consultations • Therapy (individual and group) • Provision and modification of equipment – includes: soliciting and securing funding, and the fitting and monitoring of equipment and adaptive devices	Children with developmental concerns are identified early. Children learn and practice new skills. Children experience enhanced accessibility and inclusion.	Children have optimum developmental and/or functional outcomes. Children actively participate in their home and community.	**Children experience optimal growth and development.**
	Family Support Services • Family Support • Referral • Family education and training • Assist families with arranging services and supports • Assist family with transition and discharge planning	• Intervention/service plans completed with families (IFSP and transition plans) • Consultations • Family and caregiver education and training	Families have the knowledge and skills to advance their child's growth, development and functioning. Families learn about resources and how to access them. Families actively participate in their child's planning.	Families have positive and appropriate expectations of their child. Families are empowered and provide activities and experiences that support their child's development	
	Community Capacity Building • Increase community awareness and knowledge of children special needs (activity limitation and participation restrictions). • Advocate for child and family needs in relation to inclusion and community participation (e.g. accessibility). • Promote prevention of delay and disability • Support inter-agency collaboration and coordination of services	• Community forums • Educational events • Prevention events • Community resources (e.g. toy libraries)	Resources and supports are readily accessible in the community for families.	Families are able to seek formal and informal supports when needed and connected to child-friendly, caring and inclusive communities.	

Appendix B: Overview of Services for Children and Youth with Special Needs and Their Families

The approach to caring for children and youth with special needs has evolved over the last 25 years from an institutional, medical model to one based on family and community support.[11] The current focus is on assisting families and communities to care for children with special needs at home, and supporting the inclusion of children with special needs in their schools and other community settings.

A range of services for children and youth with special needs and their families are offered through health authorities, Ministry of Children and Family Development (MCFD) regional and provincial offices, and contracted organizations, including Delegated Aboriginal Agencies. These services and supports are intended to promote children's healthy development, maximize their quality of life, and assist families in their role as primary caregivers. Services and supports for Aboriginal children and youth with special needs may also be available through programs offered by Health Canada.

The Provincial Health Services Authority (PHSA) provides a range of specialized assessment and health care services for children and youth including:

- *BC Autism Assessment Network*: A partnership between the regional health authorities and PHSA to provide multidisciplinary assessment and diagnostic services for children and youth who may have Autism Spectrum Disorder.
- *BC Early Hearing Program*: A service of PHSA and the regional health authorities that provides province-wide hearing screening to check the hearing of newborn babies.
- *Complex Developmental Behavioural Conditions Network*: A partnership between the regional health authorities and PHSA to provide multidisciplinary assessment services for children and youth with complex developmental behavioural conditions, including children and youth who may have Fetal Alcohol Spectrum Disorder (FASD).
- Programs and services available through *BC Children's Hospital* and *Sunny Hill Health Centre*.

The five regional health authorities provide child and family health services including audiology and public health speech-language pathology services.

Services available to children and youth with special needs and their families through MCFD are described below.

Ministry of Children and Family Development Services (www.mcf.gov.bc.ca/)

- **Aboriginal Infant Development Program:** Provides culturally relevant, home-based services for Aboriginal infants up to age three who are at risk of, or have, a developmental delay (services available to age six in most communities). For more information, visit *www.aidp.bc.ca/*
- **Aboriginal Supported Child Development Program:** Provides culturally relevant supports to enable Aboriginal children with special needs to participate in inclusive preschool and child care settings. For more information, visit *www.scdp.bc.ca/ASCD%20Pages/mysite/index.htm*.
- **At Home Program:** Provides medical and respite benefits to assist families in caring for children with severe disabilities at home. For more information, visit *www.mcf.gov.bc.ca/at_home/index.htm*.
  - **Medical Benefits:** Provides eligible children with essential medical supplies, medical equipment, medical transportation, therapies, orthotics, dental/orthodontic, optical, Medical

11 A child or youth with special needs is someone between birth and 19 years of age who requires significant additional educational, medical/health and social/environmental support, beyond that required by children in general, to enhance or improve his/her health, development, learning, quality of life, participation and community inclusion.

Services Plan, and PharmaCare coverage.

  - **Respite Benefits:** Provides eligible families with $2,400-$2,800 per year to purchase the respite that best meets their needs.

- **Autism Funding – Under Age 6:** Provides families of children with Autism Spectrum Disorder under age six with up to $20,000 per year to assist with the cost of purchasing autism intervention services. For more information, visit *www.mcf.gov.bc.ca/autism/programs/index.htm*.
- **Autism Funding – Ages 6-18:** Provides families of children and youth with Autism Spectrum Disorder, ages six through eighteen, with up to $6,000 per year to assist with the cost of purchasing out-of-school autism intervention services. This funding is in addition to the educational program and special education services provided through Boards of Education. For more information, visit *www.mcf.gov.bc.ca/autism/programs/index.htm*.
- **Child and Youth Mental Health (CYMH) Services:** CYMH teams include psychologists, clinical social workers, nurses, counsellors and psychiatrists who work with the child or youth to plan and deliver responsive, effective treatment and support. For more information, visit *www.mcf.gov.bc.ca/mental_health/*.
- **Community Brain Injury Program:** Plans, coordinates and funds short-term acute rehabilitation services for children and youth with acquired brain injuries when no other funding is available. For more information on this provincial rehabilitation program, visit the BC Centre for Ability website at *www.centreforability.bc.ca/*.
- **Early Intensive Behavioural Intervention:** Provides up to 20 hours per week of intensive interdisciplinary intervention for children under age six diagnosed with Autism Spectrum Disorder (ASD), through five agencies in seven communities. For more information, visit *www.mcf.gov.bc.ca/autism/programs/index.htm*.
- **Early Intervention Therapy:** Provides a network of services for early intervention and support to children with special needs and their families, including occupational therapy, physiotherapy, and speech-language pathology and family support services. For more information, visit *www.mcf.gov.bc.ca/spec_needs/eits.htm*.
- **Infant Development Program:** Provides home-based services for infants up to age three who are at risk of, or have, a developmental delay. For more information, visit *www.idpofbc.ca/*.
- **Key Worker and Family Support:** Supports families of children and youth with Fetal Alcohol Spectrum Disorder (FASD) and similar conditions through the provision of a specialized key worker and various family support mechanisms. For more information, visit *www.mcf.gov.bc.ca/fasd/support.htm*.
- **Nursing Support Services:** Provides comprehensive nursing services to children and youth with special health care needs and their families in home, school, and child care settings. Services include assessment, care planning, consultation, and training of caregivers. For more information, visit *www.mcf.gov.bc.ca/spec_needs/nursing.htm*.
- **Post-Adoption Assistance Program:** Offers financial assistance and/or access to other support services to some families who adopt or have adopted children with special service and/or placement needs.
- **Provincial Outreach and Professional Support:** Provides provincial outreach services including prescription and fitting of customized assistive devices, complex feeding and nutritional assessment and psychological assessment or consultation. Also provides professional support services for community-based therapists to develop and increase community skills and knowledge in order to better serve children with complex needs. For more information, visit *www.mcf.gov.bc.ca/spec_needs/outreach.htm*.

- **Provincial Services for the Deaf and Hard of Hearing:** Provides a range of direct and contracted services for children who are deaf, hard of hearing, or deafblind. For more information, visit *www.mcf.gov.bc.ca/psdhh/*.
- **School-Aged Therapy:** Provides occupational therapy and physiotherapy services to school-aged children and youth with special needs. It is jointly funded by Boards of Education and MCFD. For more information, visit *www.mcf.gov.bc.ca/spec_needs/school_aged_therapies.htm*.
- **Supported Child Development:** Provides the additional supports children with special needs require to participate in inclusive preschool and child care settings. For more information, visit *www.scdp.bc.ca/*.
- **Family Support:** Assists families with a range of community-based services including respite, family support groups, family skill training, homemaker/home support, child and youth care workers, counselling, life skills training, and organized activities. For more information, visit *www.mcf.gov.bc.ca/spec_needs/services_programs.htm*.

Community Living BC (CLBC) Services (http://www.communitylivingbc.ca/)

CLBC delivers support and services to individuals with developmental disabilities and their families.

Health Canada Services (www.hc-sc.gc.ca/fnih-spni/index_e.html)

Health Canada's First Nations and Inuit Health Branch works with Aboriginal and Inuit organizations and communities to deliver services and supports, including:

- **Aboriginal Head Start on Reserve:** Encourages the development of locally controlled projects in Aboriginal communities to prepare young children for their school years by meeting their emotional, social, health, nutritional and psychological needs.
- **Home and Community Care:** Provides comprehensive home and community care services that respect traditional, holistic and contemporary approaches to healing and wellness in order to assist people who have chronic and acute illnesses. Services include nursing care, personal care, home support, and in-home respite care.
- **Non-Insured Health Benefits:** Provides coverage for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention, mental health counselling and medical transportation for status Aboriginal peoples, when it is not insured elsewhere.

Appendix C: A Sample Individualized Family Service Plan Template

Child's Name:_____

Child's Date of Birth: _____

Family(s)/Guardian(s): _____

Home Telephone:_____ Alternate Telephone: _____

Home Address: _____

_____

Child Care or Community Setting: _____

Address: _____ Phone: _____

Child's Schedule of Attendance: _____

Child's Strengths:

Needs:

Child's Likes:

Dislikes:

Cultural and Ethnic Considerations:

Family's Priorities for the Child:

TEAM MEMBERS:	NAME:	PHONE:
Family(s):		
Child Care Provider:		
Infant Development Consultant:		
Occupational Therapist:		
Physiotherapist:		
Speech Language Pathologist:		
SCDP:		
Consultant:		
Support Worker:		
Other:		

SCHEDULE:	Frequency	Day/Time	Location
SCDP Support Worker			
SCDP Consultant			
Infant Development Program Consultant			
Occupational Therapy			
Physiotherapy			
Speech Language Pathology			

Goal #1

Objectives:	Person Responsible	Implemented By	Date Acquired
1.			
2.			
3.			

Goal #2

Objectives:	Person Responsible	Implemented By	Date Acquired
1.			
2.			
3.			

Goal #3

Objectives:	Person Responsible	Implemented By	Date Acquired
1.			
2.			
3.			

Goal #4

Objectives:	Person Responsible	Implemented By	Date Acquired
1.			
2.			
3.			

Goal #5

Objectives:	Person Responsible	Implemented By	Date Acquired
1.			
2.			
3.			

Next Review date: _____

cc:

BRITISH
COLUMBIA
Ministry of
Children and Family
Development