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Occupational Therapists' Perspectives on Family-Centered Practices in Early Intervention

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Abstract

Background: Early intervention (EI) requires service provision in natural settings while incorporating interventions based on family-centered practice (FCP). This study sought to understand (a) how occupational therapists define and implement FCP in their daily interventions and (b) therapists' perspectives on using this model of practice in EI.

Method: This study used a qualitative, phenomenological approach. Nine licensed occupational therapists from six states with a minimum of 3 years of working experience in the area of EI participated. Semi-structured interviews were recorded, transcribed, and subsequently coded and analyzed for emergent themes.

Results: The therapists had an average of 12.6 years of experience in EI. Four themes were identified: (a) confusion on meaning and implementation of FCP, (b) FCP creates feelings of insecurity, (c) FCP requires therapists to assume roles and engage in activities or practices for which they are not prepared, and (d) systemic issues affect the ability to implement FCP in EI.

Conclusion: The participants reported limited evidence-based practice guidelines on FCP models and emphasized the need for training to have a commonality in defining and implementing FCP. Findings indicate a need to address systemic issues affecting how services are approved, delivered, and funded.

Comments

The authors report no potential conflicts of interest.

Keywords

early intervention, family-centered practice, parent coaching, parent training

Credentials Display

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Part C of the Individuals with Disabilities Education Act (IDEA) (2004) mandates intervention for infants and toddlers from birth to 36 months of age with diagnosis(es) with a high probability for developmental delays, such as Down's syndrome or cerebral palsy, and/or with suspected delays in one or more of the five developmental domains that include cognitive, communicative, physical, social-emotional, and adaptive skills and abilities. Eligibility for early intervention (EI) services is determined by each state's program, which varies across the country. The EI program is geared toward positively impacting the child's development and supporting their families in meeting the distinct needs of their children. In 2018, approximately 389,000 infants, toddlers, and their families participated in EI programs under IDEA in the US. Health professionals, including occupational therapists, are commonly used to provide services under IDEA Part C (Nwokah et al., 2013). Defined as primary service providers of EI under IDEA Part C, occupational therapists work with children and their families and caregivers to promote active participation in meaningful occupations in the context of daily routines (American Occupational Therapy Association [AOTA], 2011). Therapists collaborate with parents to develop strategies to help the child master skills in the context of play, daily routines, and other significant family activities (AOTA, 2011). According to the AOTA (2008), occupational therapists focus on the importance of positive well-being in both the individual child and their families. Their knowledge of how performance skills affect the client and the family's occupations in participating in meaningful activities in their family nucleus and in the community in which they live allow occupational therapists to be distinctly positioned to improve parent-child co-occupation.

IDEA Part C, Subpart A, § 303.13 (2004) states related services are selected in collaboration with the parent and are designed to meet the needs of the family to assist in the infant's or toddler's development. In addition, IDEA indicates services should be provided to the maximum extent possible in a child's natural learning environment, including home and community settings. The use of a family-centered practice (FCP) has become the foundation of EI to meet this mandate (Kuo et al., 2011). FCP is an umbrella term used to describe interventions that focus on the inclusion of parents and caregivers and includes such specific intervention strategies as coaching, modeling, or training. When using FCP, therapists facilitate collaboration with the family by treating them with dignity and respect, providing them with the information needed to make informed decisions and choices, and actively involving families in obtaining resources and supports (National Resource Center for Family-Centered Practice, 2019). The use of FCP requires therapists to be responsive and flexible to family requests and desires (National Resource Center for Family-Centered Practice, 2019). Implementing FCP improves the ability of the family to learn how to encourage their children's participation in everyday situations and is the focus of intervention (IDEA, 2014). FCP emphasizes the primary and crucial role parents and caregivers have in building a child's capacities. It is a strengths-based model that helps parents make decisions they consider essential for their families, thereby allowing them to take control of their lives (Davis & Gavidia-Payne, 2009).

AOTA provides guidance for its therapists in the area of EI but does not endorse a particular model or approach for EI service delivery, as they state further research is needed (AOTA, 2008, 2011, 2014; Fabrizi et al., 2016). IDEA requires parents to be an integral part of the delivery of EI services, and multiple states recommend or require a coaching model in EI service delivery, with varying requirements for therapists training in its use (Massachusetts Department of Health, 2013). Several occupational-therapy specific FCP models have been developed for working with parents and caregivers (Graham et al., 2009; Kessler & Graham, 2015). The occupational performance coaching model uses a collaborative

problem-solving framework to guide parents in solving their child's occupational performance challenges; therapists coach parents to identify ways of facilitating their child's occupational performance to support goal achievement by engaging in occupations (Graham et al., 2009, 2013). The contextual intervention is designed for children with autism spectrum disorder and incorporates the family's natural environment, everyday routines, and the child's sensory processing patterns (Dunn et al., 2012).

The evidence indicates using coaching models in the area of pediatrics is beneficial for the child-family dyad, and it has a positive impact on parents' self-efficacy and their ability to more effectively address their children's needs (Salisbury & Copeland, 2013); however, it is also clear that coaching requires active participation from parents (Salisbury et al., 2010). Providers are familiar with the importance of collaborating with the family during their treatment sessions. Still, they are often unsure of or skeptical about the use of coaching as an approach to intervention in EI. Many therapists do not know how to guide caregiver engagement in the process. Therefore, EI service providers must have adequate and continuous training to effectively implement this model of intervention (Campbell & Sawyer, 2009; Friedman et al., 2012; Marturana & Woods, 2012; Stewart & Applequist, 2019) to allow their interventions to align with the requirements of IDEA Part C (Friedman et al., 2012; Marturana & Woods, 2012; Salisbury et al., 2010).

As the evidence suggests, a lack of consistency in how FCP is defined and implemented as well as a dearth of programs providing sufficient and on-going therapist training to develop effective and practical skills to engage parents as part of FCP is warranted. Examining therapists' understanding of FCP and how they are using this model of practice is needed. Therefore, the purpose of this study was to explore the following questions: (a) how do occupational therapists define and implement FCPs in their everyday interventions, and (b) what are occupational therapists' perspectives on using FCPs with parents in EI?

Method

Research Design

A qualitative, phenomenological approach was used to assess how practicing occupational therapists in EI define and implement FCP as well as their thoughts and beliefs regarding the use of FCP.

Sample and Recruitment

Inclusionary criteria included licensed occupational therapists with a minimum of 3 years of working experience in the area of EI, who reside in the United States, and who were able to understand and respond to questions verbally posed in English. The study was approved by the Quinnipiac University Human Subject Institutional Review Board. A recruitment flyer, including purpose and contact information, was posted to a variety of occupational therapy Facebook groups as well as on AOTA's CommunOT. Study procedures were discussed with the participants who indicated interest in the study, including emailing consent forms to the participants once they had expressed willingness to participate. Nine participants were eligible to participate in the study from an initial pool of 10 that expressed interest.

Instrumentation

A semi-structured video interview was developed based on an extensive review of the literature, as noted above, and on the personal experiences of the researchers to explore how the participants defined and implemented FCP in their interventions and their perceptions of the use of the model in their practice (Friedman et al., 2012; Graham et al., 2013; Marturana & Woods, 2012; Stewart & Applequist, 2019). Additional probes were used to have the participants provide detailed descriptions of their perceptions of engaging families in therapy sessions, their understanding of parent engagement models of intervention,

their knowledge of FCP, and their awareness of their role in EI. See Table 1 for the sampling of interview questions.

Table 1

Sampling of Interview Questions

- Can you provide some examples of topics or classes that you have taken to assist you in your work in EI and collaborative FCP?
- How would you define FCP as it relates to occupational therapy and your work in EI?
- How would you explain FCP to a parent?
- What do you feel are the best ways for parents to learn how to do the carry-over of activities you work on?
- Describe how do you involve the parent in what will be worked on in the session?
- Can you give an example of how you and other EI team members collaborate with the family?
- Can you tell me about a time when you worked with a parent and you felt it was a successful session?
- Can you tell me about a time when you were working with a family and it was not going well?
- Can you tell me about a time when you had a parent that did not want to participate and how you dealt with that? How did you explain it to the on-going service coordinator? How did you document it in your progress report?

Data Collection

Data was collected via audio and web-based videoconferencing. All interviews were transcribed verbatim. Transcripts were reviewed and coded using a constant comparative method (Dillaway et al., 2006; Fram, 2013; Stahl & King, 2020). To increase the rigor and trustworthiness of the data, the secondary researcher reassessed coding and thematic development. Discrepancies in coding were discussed and agreed on by both researchers prior to determining final codes and themes.

Data Analysis

Each interview was transcribed, and the transcriptions were reviewed along with the audio recording to ensure the accuracy of the transcription. A reflection journal and discussion of emerging themes among the researchers were used to validate the findings from the interviews. A codebook was used to analyze the data. Codes were applied to each participant's meaningful statement. Codes were analyzed for recurring categories and themes and then collapsed into categories that were culled for emergent themes. The codebook, journal, and transcripts have been securely stored on a password-protected laptop and will be permanently deleted after 3 years from the study.

Results

Participants

Nine occupational therapists agreed to participate in the study from the pool of 10 candidates that expressed initial interest in participating. The participants ranged from 4.6 years to over 33 years in practice. Their experience specific to EI ranged from 4.6 years to over 28 years. The nine participants were located in six different states (MA, NY, Il, KY, NC, PA); one therapist worked in two of the states. The participants worked in urban, suburban, and rural areas, as well as in military-based communities. Therapy services were delivered in the child's home, typical daycares, center-based EI programs, and therapy clinics and facilities. See Table 2 for details on the participant demographics.

Table 2
Demographic Data

Participant	Years of experience as an OTR	State	Years of experience in EI	Community Type	Service Delivery Settings	Employment Status
P1	4 ½	MA	4 ½	U & S	HB & DC	E
P2	35	NY	22	U	HB	IC
P3	5	MA	4 ½	U & S	HB & CB	E
P4	35+	IL	20	U & S	HB & DC	IC
P5	23	NY	28+	U	HB & FB	IC
P6	30+	KY	20+	U & S	HB & DC	IC
P7	7.5	NY	6.5	U	HB & CB	IC
P8	21	NC & KY	11	Rural/Military Bases	FB	IC
P9	33	PA	3	U	HB	IC

Note. The average practical years of experience was 21.44 years. The average EI experience was 12.61 years. Community type: Urban (U), Suburban (S); Service Delivery Setting: Home-based (HB), Daycare (DC), Facility/Clinic-Based (FB), and Center-Based (CB); Employment Status: Employee (E), Independent Contractor (IC).

Thematic Themes

Four major themes emerged from the study. The themes indicate that occupational therapists continue to struggle with models of intervention that implement FCP services, specifically when they are labeled as "coaching models." All of the participants described that they could collaborate with parents to develop strategies on those identified areas to help the child master skills in the context of play, daily routines, and other significant family activities (AOTA, 2008, 2011, 2014). The participants also indicated that they were confused with the jargon related to FCP models. They discussed the difficulties in solely providing the service and being required to assume responsibilities outside of their scope of practice. They described the lack of consistency in follow-up, training, and job retention; these findings parallel the literature (Bowyer et al., 2017; Fingerhut et al., 2013; Leinwand et al., 2018). Final themes emerging from the interview data fell into four broad categories: (a) there is confusion in defining FCP and how it should be implemented, (b) coaching and collaborative models create insecurity, (c) FCP requires therapists to assume roles and engage in activities or practices for which they are not prepared, and (d) there are systemic issues that impact delivering EI services using a FCP mode (see Figure 1).

Theme 1: Confusion on how to Define and Implement FCP

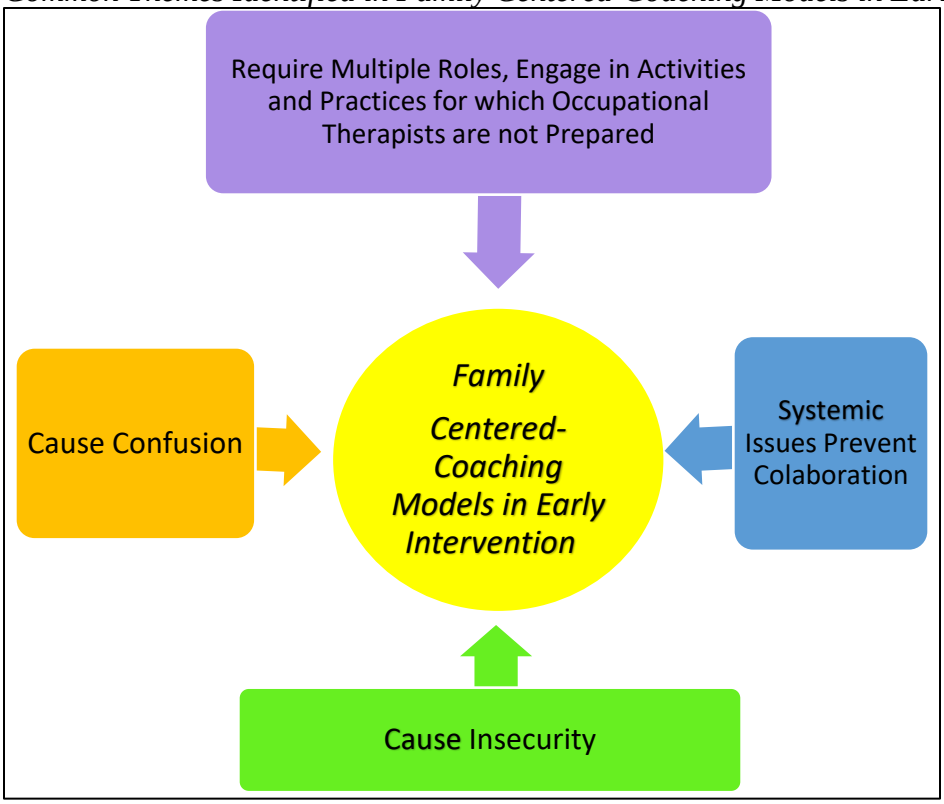
The participants had difficulty describing how the occupational therapy profession defined FCP overall. Participant 4 stated, "I guess they define that FCP is EI." They also struggled with defining and explaining the differences in terminology used to describe how to engage parents using FCP and defining important terms used when working in a family-centered model such as family-centered practices, parent training, and parent coaching. For example, when explaining FCP, Participant 9 stated, "FCP is not a medical model approach as I look at the family as a whole and not just what I see clinically after observing the child." This participant, when probed further on what she meant by it "not being a medical model," reported that

> in a medical model we treat the symptoms of the child, but here we need to see the child in the context of the family and their home . . . so, you don't only treat the symptoms to make the child better but have to treat the family so that they can help the child.

Several of the participants responded that in FCP, the focus is on treating the whole family and not just treating the child, asking what is important to the parents concerning their child, and teaching them skills to help their child. Participant 5 stated that in "FCP, I focus on empowering the parents." When she was asked to define the word empowering, she responded that "the therapist helps the parent to help their child."

Figure 1

Common Themes Identified in Family Centered-Coaching Models in Early Intervention



The participants were asked to define the term parent training. Many of the responses included teaching the families, showing them what to do, providing parents with tools or tips to help their child, and teaching techniques, including the reasons why we use them. Participant 7 responded, "Parent training is teaching the parent to become therapists." The participants' definition of the term parent coaching emphasized the verbal component of the process whereby the therapist explained to the parent what they should do. A common thread in their responses was that in parent coaching, therapists do not touch the child, as only the parent does the handling or "hands-on," while the occupational therapist guides the parent. Participant 3 described it as the "occupational therapist guides the parent verbally through the task and provides them feedback on the execution of the task." Some of the participants expressed negative feelings when explaining parent coaching. "I don't want to burden families by having them do my job, my expertise" (Participant 8). Participant 4 stated, "I don't coach, I do modeling; I don't know anyone who really wants to coach parents." Most of the participants stated that parent training and parent coaching are not the same terms but that they are used interchangeably in the session, "they overlap" (Participant 7). Several of the participants reported that the main difference is that in parent training the occupational

therapist has a more "hands-on" approach as they teach and provide feedback to the parent, while in parent coaching the focus is on the therapist watching the parent practice while giving feedback.

When asked about the models of intervention used to guide their interventions, the participants reported various framework models to guide their sessions that were not classified as coaching or training models. Some of their answers included intervention models, such as sensory integration, models learned from textbooks, and handling and positioning models (e.g., the Model of Human Occupation, Neuro-Developmental Treatment [NDT], and the biomechanical frame of reference). The majority of the participants indicated that they used their professional and personal experiences to guide their sessions instead of specific intervention models. Participant 6 responded that "occupational therapists are starting to use evidence-based practice in EI, but a lot of the work is just passed down from experience." To gauge therapists' awareness of occupational therapy-specific FCP models, they were asked if they had heard of or used the Occupational Performance Coaching Model. Although some had heard of it, all of them stated that they did not use it in their practice. Although many of the participants reported that they did not use a coaching model to guide their interventions, when asked to describe how they teach parents carry-over activities, they responded with "coaching, modeling, have the parents do it and give feedback, and hands-on to the parent."

All of the participants reported that they wanted the parents to be in the sessions, even if it is only part of the time, because the child does make progress when the family is involved. Several of the participants indicated that the relationship between the therapist and the parent was better when the parent was involved in the session because they asked questions, were interested, and wanted to try the activities. The parents were eager to speak about something they had tried on their own and expressed excitement when their child had done a task for them without the therapist being present. Participant 9 referred to the therapist-parent relationship as "collaborative mentality." Although the therapists noted the positive outcomes of involving parents in their sessions, most of the participants reported not having the skill set to facilitate parent participation. They also said not knowing how to bring them back to the session if they left. The participants indicated they did not want to "intrude on their time," "be pushy," and did not know how to teach them skilled tasks, such as "where to place their hands" on the child.

Theme 2: FCP Coaching and Collaborative Models Create Insecurity

The theme of insecurity was present throughout the various topics of inquiry. Issues of insecurity related to professional identity were recurrent throughout responses, especially in questions related to teaching or coaching parents. Participant 7 stated that "occupational therapists need to feel sure and comfortable about their skills before teaching parents." Several of the participants reported that many times it was difficult to explain what occupational therapists do in simple layman's terms, for example, when they had to describe sensory integration techniques and why they are used. They reported that parents and other professionals do not understand the work that occupational therapists do and that they struggle to describe their role. The participants also expressed having concerns with other EI professionals, as many of them reported working on "sensory integration" and activities of daily living skills, which they believed were distinct to the occupational therapy scope of practice. Participant 5 stated, "services tend to overlap and are not clearly defined, as parents confuse occupational therapy, physical therapy, and speech therapy providers." Some of the participants reported having feelings of insecurity about their role as an occupational therapist on the team.

Other areas in which the participants expressed insecurity were documenting coaching models as "skilled services" and concerning liability issues. The majority of the participants reported that it was

difficult for them to write notes that were both parent-friendly and noted skilled services. "We are not taught how to write parent-friendly notes in school" (Participant 1). All of the participants reported being uncertain of how a session geared on coaching or training a parent is considered a therapeutic intervention. Participant 6 stated, "we bill medical insurances/Medicaid, so notes must look like clinical-skilled service, but EI wants family-friendly, no hands-on, only coaching." The therapists expressed having ethical concerns in documenting, and many of them reported that they use key phrases in their notes, such as "parent input/report," "parent training is on-going," or "with skilled occupational therapy service two out of three trials." Some of the participants reported that they allow videotaping the session or taking pictures as a learning tool since the parent can refer back to it if they have a question. Still, the participants were not sure if this was allowed. Several of the therapists also expressed liability concerns if the parent accidentally hurt the child with a carry-over task.

In addition, the participants had difficulty documenting when parents do not wish to participate in sessions as many of the participants indicated that most of the time, families are not present. Most of the participants reported they do not include this in their daily session notes or progress reports because of fear of parent repercussions in terminating services. An argument made by Participant 5 was that "EI is a voluntary program, so why do we have to document if parents were involved in the session." A common response was that as therapists, they need to advocate for what is suitable for the child, for themselves as providers, and for better implementation of the FCP model.

Theme 3: FCP Requires Therapists to Assume Roles and Engage in Activities or Practices for Which They are not Prepared

The participants all expressed that they did not feel prepared working for EI. The therapists indicated they felt as though they were acting in the role of psychologists, marriage counselors, babysitters, hired help, emotional therapists, and teachers of "common sense." The participants expressed that there are boundaries that they cannot cross with families, and being effective while staying in those boundaries is challenging. "Sometimes the lines get blurry when you do homecare" (Participant 7). Some of the participants reported that they have to build trust with the families and, in doing so, the lines can become blurred. Participant 7 gave an example of a parent who did not have many friends and wanted to have a closer relationship with her, making the participant feel uncomfortable.

The participants indicated that they frequently have to help families with issues that are unrelated to occupational therapy practice. An example mentioned by Participant 9 included having to go to "Goodwill to buy the family feeding utensils and buy food to mash to teach them how to feed their child." The therapists reported that they are often placed in positions where they feel they need to purchase toys, clothing, groceries, diapers, or other items to help the families make ends meet. Some of the therapists reported they had to help the families in setting up their home to keep the child safe, which included cleaning and purchasing furniture (table, chairs, highchair).

The participants also reported that in providing EI services, they need to understand cultural awareness and cultural competency issues. All of the therapists that worked in urban communities reported difficulty in being able to communicate with parents and to understand the families' inherent cultural differences. For example, some of the participants said that they had to use extended family members to help translate what they were trying to teach the parent. When asked about cultural diversity, Participant 9 responded, "respecting the family hierarchy of living arrangements, culture, and dynamics will help to strengthen the family to participate." The participants reported having difficulty finding resources to help parents, as there is limited information available for all socioeconomic groups. Another distinction made

by the participants included the vast needs of disadvantaged families. "Usually, families with lower socioeconomic status need more help" (Participant 9). They reported that these families face many issues that may be more important than sitting in a therapy session.

Theme 4: Systemic Issues Affecting FCP in EI

The fourth theme involved the systemic problems that affect the delivery of family-centered services in EI. The therapists felt that properly addressing these areas would make EI a "better program" (Participant 5). These areas included the lack of professional and "on the job" training specific to FCP, difficulty with team collaboration because of scheduling issues preventing multiple providers from concurrently meeting with the family, a disconnect between written goals and actual skill level of the child, and the lack of parent education and training in the model of FCP.

While all of the participants reported that their states require a certain number of continuing education hours in areas relevant to EI, most of the participants reported that their states do not offer training on FCP. At the same time, the two that worked in Massachusetts said that their EI program provides comprehensive training on FCP. However, the therapists reported that these hours do not count toward their required continuing education units (CEU) for their professional license renewal. Participant 9 responded, "I would like to attend training that also counts toward my CEUs for licensing and certification renewal." In describing the lack of on-the-job training, several of the participants reported feeling unsafe in specific communities or homes and did not know if they should stop seeing the child. For example, several of the participants discussed the experience of coming into a home where the parents were intoxicated and not knowing how to handle this situation appropriately. The participants also reported that they never received an orientation or training on how to get families involved when they are reluctant to participate.

When they discussed team meetings, the participants commented that many do not receive payment for these meetings, they are not scheduled at a convenient time, or many therapists cannot attend because of billing issues. Several of the participants said children's goals are not relevant to the child's current level of function and reported goals were too advanced for the child to achieve. The participants reported that when they reviewed the goals with the parents by explaining the developmental sequence for attaining the goal, parents reported having been confused during the initial meeting. All of the participants responded that they did not think parents understood the concept of FCP. Participant 1 stated, "they don't understand learning in natural settings." The participants said that EI programs need to improve educating parents on FCP.

Discussion

The prevalence of infants and toddlers requiring EI services is anticipated to rise, resulting in an increased need for service providers trained to work collaboratively with parents to meet the mandates of FCP as a component of IDEA Part C. The purpose of this research study was to explore how occupational therapists working in EI defined and implemented FCP and their perceptions on the use of such models with their interventions. In the context of this study, four main themes emerged: confusion on meaning and implementation of FCP, FCP creates insecurity, FCP requires therapists to assume roles and engage in activities or practices for which they are not prepared, and systemic issues that affect delivering EI services in the FCP model.

The participants in this study reported challenges in providing FCP, aligning in areas also identified by Bowyer et al. (2017), which included difficulty in collaborating with families and other service providers, managing family dynamics, and providing parent support resources in the family's

native language. One of the significant areas of difficulty verbalized by the participants included family barriers. Examples of these barriers included working with families who do not appear to understand the concept of FCP, families that do not speak the English language, the socioeconomic status of the family, and personal stressors that affect families. These findings are similar to those of Fingerhut et al. (2013) whose study found family barriers (language barriers, socioeconomic status, culture, and personal stressors) and professional barriers (abiding by program mandates, lack of resources for training, and understanding how to implement FCP across various practice settings) were the two main areas that impacted the use of FCP. Occupational therapists in this study stated they include parents in sessions and address their concerns and priorities for their child, following what is considered best practice professional guidelines. However, the participants still expressed confusion in their role as EI occupational therapists in using models of interventions based on building on family strengths, which is similar to the findings of Fingerhut et al., who reported occupational therapists did not understand how to implement the FCP model.

All of the participants indicated having reservations about using the word "coaching" to describe their interventions as they stated that coaching was not a skilled service to the family. The therapists did not feel that coaching was evidence-based, and they did not think it was a skilled intervention. In addition, they reported being unaware of occupational therapy specific coaching models, such as the Occupational Performance Coaching Model. However, despite their reluctance to use the word coaching or their knowledge of particular coaching models, interventions that the participants described used many components and behaviors associated with coaching models (Friedman et al., 2012). The therapists appeared to view "coaching" negatively and thought that it underscored what they did. The participants preferred the word "training," as they reported this word to be different because it implies that the therapist shows the parent what to do. The term "training" was noted as skilled service.

The participants in this study emphasized the need for proper training in the area of FCP and collaborative interventions to be able to implement these strategies more successfully in their practice, which aligns with the results of An et al. (2017) where they indicated that trained therapists in the collaborative intervention are better able to use these strategies to engage parents. There was a lack of uniformity in the requirements across the six states represented in the sample. Therapists who are independent contractors reported that their EI programs lack supervision and training. Even those who worked in Massachusetts, which uses a centralized program and training for EI providers, found that they benefited from supervision and mentorship programs implemented to help educate and train them in delivering services using a FCP model. A common thread across the participants was that providing EI services should be a specialty area in pediatrics, as it requires advanced clinical knowledge and a solid professional identity. The more experienced participants stated that trained occupational therapists should provide EI services, not new therapists. Participant 1, with 4.6 years of experience, reported that "EI is harder than it seems" and "doing it is harder than learning how to do it."

A contribution provided by the study was the participants' perceptions on systemic issues that affect the delivery of FCP services in EI. They reported the lack of parental education in FCP as an area that needs improvement throughout the EI process; this finding was also noted in work done by Bowyer et al. (2017). The participants stressed the need for written EI documentation, including treatment programs and EI resources, to be in the family's primary language. The therapists indicated concerns with parent education related to FCP models, including explaining their role as parents when using FCP strategies and how this model is implemented during treatment. In addition to the lack of clarity in

providing information for parents, the therapists consistently noted concerns with responsibility for their FCP provider training.

The participants reported they believed it is their state's EI program's responsibility to provide training on implementing evidence-based FCP. Still, they stated that training is not occurring on a consistent basis. Based on the participants' responses, there appeared to be a significant difference between therapists that are independent contractors and those that are employed, as the participants that were employees were more likely to have received training, supervision, and mentorship. The participants reported concerns about the lack of opportunities to collaborate with other team members, including team meetings with parents, since the program's emphasis is to work collaboratively. Issues that impacted team collaboration included scheduling, reimbursement, and not being informed of meetings. Based on the study's findings, additional education related to the use of FCP and coaching models for those therapists working in EI appears warranted as there continues to be confusion in the implementation of the model and how the model supports best practices in EI.

Although the researchers felt they had achieved saturation in the data, a main limitation of the study included a lack of national representation, as the participants were practicing in only six states, with half of them from the Northeast. This limitation may not indicate how occupational therapists from other geographic areas perceive parent collaboration or be reflective of individual state practices requiring or providing training. Participant bias should also be considered a limitation in generalizing findings. Only 10 therapists volunteered to be part of the study from what would be considered a large pool of potential participants with the use of social media as the primary recruitment tool.

The findings of this study support several areas for future research. Based on the systemic issues noted by the participants, the perspectives of service coordinators and EI officials in collaborating with parents and educating them regarding family-centered services appear warranted. Another area of further inquiry is parents' perspectives on receiving EI services using a FCP model. Finally, there is a need to investigate and establish evidence-based practice training programs for therapists in delivering services using a FCP model.

FCP is an umbrella model of service delivery in EI, as it meets the guidelines set forth by IDEA Part C, to enhance the family's capacity to meet the needs of their infants and toddlers with disabilities (Section 1431(a) of IDEA, 2004). Using a FCP model, therapists collaborate with the family throughout the EI processes of evaluation and intervention as it concerns their children. The literature identifies a multitude of varying concepts and behaviors associated with the implementation of FCP, such as coaching, training, embedded coaching, collaboration, teaching, and engagement. There are coaching model guidelines that are currently used in practice (Blanche et al., 2016; Graham et al., 2016; Rush & Shelden, 2020). The development of consistent terminology, professional guidelines, and initial and on-going training appear needed to aid therapists in being more confident and effective in implementing FCP in their service delivery.

References

American Occupational Therapy Association. (2014). *Role of occupational therapy with infants, toddlers, and families in early intervention* [PowerPoint slides]. http://www.aota.org/-/media/Corporate/Files/Secure/Practice/Children/EI.pdf

American Occupational Therapy Association. (2011). Occupational therapy services in early childhood and school-based settings. *American Journal of Occupational Therapy*, *65*(suppl. 6), S46–S54. https://doi.org/10.5014/ajot.2011.65s46

American Occupational Therapy Association. (2008). Occupational therapy practice framework: Domain and process (2nd ed.). *American Journal of Occupational Therapy*, *62*, 625–683. https://doi.org/10.5014/ajot.62.6.625

An, M., Palisano, R., Yi, C-H., Chiarello, L., Dunst, C., & Gracely, E. (2017). Effects of a collaborative intervention process on parent empowerment and child performance: A randomized controlled trial. *Physical & Occupational Therapy in Pediatrics*, *39*(1), 1–15. https://doi.org/10.1080/01942638.2017.1365324

Blanche, E., Chang, M., Gutiérrez, J. & Gunter, J. (2016). Effectiveness of a sensory-enriched early intervention group program for children with developmental disabilities. *The American Journal of Occupational Therapy*, *70*, 700522001p1-700522001p10. https://doi.org/10.5014/ajot.2016.018481

Bowyer, P., Moore, C., Tiongco, C., Tkach, M., & Thom, C. (2017). Perspectives of occupational therapists on the challenges of early intervention practice: A pilot study. *Journal of Occupational Therapy, Schools, & Early Intervention*, *10*(1), 18–26. https://doi.org/10.1080/19411243.2016.1257966

Campbell, P. H., & Sawyer, L. B. (2009). Changing early intervention providers' home visiting skills through participation in professional development. *Topics in Early Childhood Special Education*, *28*(4), 219–234. https://doi.org/10.1177/0271121408328481

Davis, K., & Gavidia-Payne, S. (2009). The impact of child, family, and professional support characteristics on the quality of life in families of young children with disabilities. *Journal of Intellectual and Developmental Disability*, *34*(2), 153–162. https://doi.org/10.1080/13668250902874608

Dillaway, H., Lysack, C., & Luborsky, M. R. (2006). Qualitative approaches to interpreting and reporting data. In G. Kielhofner (Ed.), *Research in occupational therapy: Methods of inquiry for enhancing practice* (pp. 341–357). F. A. Davis.

Dunn, W., Cox, J., Foster, L., Mische-Lawson, L., & Tanquary, J. (2012). Impact of a contextual intervention on child participation and parent competence among children with autism spectrum disorders: A pretest-posttest repeated-measures design. *American Journal of Occupational Therapy*, *66*(5), 520–528. https://doi.org/10.5014/ajot.2012.004119

Fabrizi, S. E., Ito, M. A., & Winston, K. (2016). Effect of occupational therapy-led playgroups in early intervention on child playfulness and caregiver responsiveness: A repeated-measures design. *American Journal of Occupational Therapy*, *70*(2), 1–9. https://doi.org/10.5014/ajot.2016.017012

Fingerhut, P., Piro, J., Sutton, A., Campbell, R., Lewis, C., Lawji, D., & Martinez, N. (2013). Family-centered principles implemented in home-based settings, clinic-based, and school-based pediatric settings. *American Journal of Occupational Therapy*, *67*(2), 228–235. https://doi.org/10.5014/ajot.2013.006957

Fram, S. M. (2013). The constant comparative analysis method outside of grounded theory. *The Qualitative Report*, *18*(1), 1–25. https://doi.org/10.46743/2160-3715/2013.1569

Friedman, M., Woods, J., & Salisbury, C. (2012). Caregiver coaching strategies for early intervention providers: Moving toward operational definitions. *Infants and Young Children*, *25*(1), 62–82. https://doi.org/10.1097/iyc.0b013e31823d8f12

Graham, F., Rodger, S., & Ziviani, J. (2013). Effectiveness of occupational performance coaching in improving children's and mothers' performance and mothers' self-competence. *The American Journal of Occupational Therapy*, *67*(1), 10–18. https://doi.org/10.5014/ajot.2013.004648

Graham, F., Rodger, S., & Ziviani, J. (2009). Coaching parents to enable children's participation: An approach for working with parents and their children. *Australian Occupational Therapy Journal*, *56*(1), 16–23. https://doi.org/10.1111/j.1440-1630.2008.00736.x

Graham, F., Rodger, S., & Ziviani, J., & Jones, V. (2016). Strategies identified as effective by mothers during occupational performance coaching. *Physical and Occupational Therapy in Pediatrics*, *36*(3), 247–259. https://doi.org/10.3109/01942638.2015.1101043

Individuals with Disabilities Education Act. (2004). *20 USC § 1400. Short title; findings; purposes*. https://sites.ed.gov/idea/statute-chapter-33/subchapter-i/1400

Kessler, D., & Graham, F. (2015). The use of coaching in occupational therapy: An integrative review. *Australian Occupational Therapy Journal*, *62*(3), 160–172. https://doi.org/10.1111/1440-1630.12175

Kuo, D. Z., Houtrow, A. J., Arango, P., Kuhlthau, K. A., Simmons, J. M., & Neff, J. M. (2011). Family-centered care: Current applications and future directions in pediatric health care. *Maternal and Child Health Journal*, *16*(2), 297–305. https://doi.org/10.1007/s10995-011-0751-7

Leinwand, R., Cosbey, J., & Sanders, H. (2018). Better together: Team collaboration in early intervention. *American Occupational Therapy Association SIS Quarterly Practice Connection*, *3*(1), 7-9.

Marturana, E. R., & Woods, J. J. (2012). Technology-supported performance-based feedback for early intervention home visiting. *OT Topics in Childhood Special Education*, *32*(1), 14–23. https://doi.org/10.1177/0271121411434935

Massachusetts Department of Public Health. (2013). *Early intervention operational standards July 2013*. https://www.mass.gov/files/documents/2016/07/nw/ei-operational-standards.pdf

National Resource Center for Family-Centered Practice. (2019). *What is family-centered practices?* https://clas.uiowa.edu/nrcfcp/what-family-centered-practice

Nwokah, E., Hsu, H., & Gulker, H. (2013). The use of play materials in early intervention: The dilemma of poverty. *American Journal of Play*, 5(2) 187-218. Retrieved from https://files.eric.ed.gov/fulltext/EJ1003950.pdf

Rush, D., & Shelden, M. (2020). *The early childhood coaching handbook.* Paul H. Brookes Publishing Company.

Salisbury, C. L., & Copeland, C. G. (2013). Progress of infants/toddlers with severe disabilities: Perceived and measured change. *Topics in Early*

Childhood Special Education, *33*(2), 68–77. https://doi.org/10.1177/0271121412474104

Salisbury, C. L., Woods, J., & Copeland, C. G. (2010). Provider perspectives on adopting and using collaborative consultation in natural environments. *Topics in Early Childhood Special Education*, *30*(3), 132–147. https://doi.org/10.1177/0271121409349769

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*, *44*(1), 26–29.

Stewart, S. L., & Applequist, K. (2019). Diverse families in early intervention: Professionals' views of coaching. *Journal of Research in Childhood Education*, *33*(2), 242–256. https://doi.org/10.1080/02568543.2019.1577777