Final Report:

Services Centred on the Needs of the Child

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Executive Summary

Information was retrieved from academic and grey literature and a survey of service providers, to inform the work of Macaulay Child Development Centre regarding frameworks that put the child at the centre of services. Themes from this research are highlighted in this report and executive summary.

Frameworks that Put the Child at the Centre

An example of a child-centred framework was retrieved, describing a state-wide approach to support early learning curriculum. Teachers used the questions and interests of children to plan and stage learning activities.

Family Resilience Practice Framework

Family resilience practice frameworks are valuable for services working with families facing serious challenges. This approach can assist with healing and recovery from crisis, trauma, and loss; navigating changes; thriving despite adversity; chronic conditions; and positive development of children.

Social Paediatrics

The social paediatrics approach was designed to improve access to services in vulnerable populations and to ensure services were responsive to the needs of children at risk. Priorities included continuity of care, local outreach services, recognising adverse childhood events, streamlining referrals, and addressing conditions that contributed to the concerns.

Socio-economic Status

To address the pervasive impacts of socio-economic status, recommended approaches include raising awareness, building provider skills, coordinating services, focusing on early intervention, teaching parenting skills, providing quality child care, meeting basic needs, and offering home visiting.

Trauma-informed Approaches

Key components of a holistic approach to trauma-informed practice can include establishing principles, policies and practices; providing staff training; forming partnerships; avoiding re-traumatization; planning ahead; using screens and assessments; providing services for children/families affected by trauma; supporting providers; monitoring and evaluating.

Seamless Services

Service delivery can be strengthened through service coordination and staff training (see section on Social Paediatrics).

Voices of Children

Examples of approaches to hearing the voices of children include:

- Using questions and interests of children to develop activities to meet learning standards.
- Developing ways to be responsive to children's concerns, for example in medical practices.
- Asking a child to draw a picture of a particular concept.
- Using drawings, pictures, photographs and props to eliciting responses and conversation.
- Using focus groups or interviews with pairs of children.
- Engaging a child in casual conversation while participating in an activity with him or her.
- Having an advocate/ interpreter for the child.

Terminology that Puts the Child at the Centre

Child-centred terminology emphasizes and respects the primary importance of meeting the needs of children; however, it does not refer to the important role of the family. The shift from *client-centred* to *family-centred* services for adults and children recognized that children need to be treated in the context of their family. *Child and family centred care* is collaborative, respectful, and important to the provision of services for children. An online survey of providers showed a clear preference for the term *child and family centred*, over the term *child centred* services.

Background

Call for Proposals

The Macaulay Child Development Centre (MCDC) released a call for proposals to develop a report summarizing research regarding service excellence in the area of services centred on the child.

MCDC

Established in 1932, MCDC is a multi-service, child care and family support agency that promotes the optimal development of children in partnership with their family and community. Macaulay programs share a common commitment to prevention, early intervention and inclusion of children with special needs, serving 7,000 children and their families every year through a full continuum of services including:

- Ontario early years centres (OEYCs)
- Family resource programs
- Parent education and support programs
- Licensed child care programs
- After school programs
- Special needs services

Putting the Child's Needs at the Centre of Services

MCDC's focus is meeting the needs of children while also acknowledging the role of the family, community and society. They want to ensure that their services continue to use evidence-based and trauma-informed approaches in meeting the needs of children. MCDC endeavours to offer a continuum of services that meet the needs of children, addressing any challenges in transitioning to new services within the organization. MCDC wants to assess approaches that put the child's needs in the centre, including seamless, barrier-free services.

Best Start Resource Centre (BSRC)

This report was prepared by BSRC, a key program of Health Nexus (non-profit organization that promotes healthy, equitable and inclusive communities through training, consultation, knowledge exchange, and network development). BSRC is experienced in implementing significant preconception, prenatal and child health projects. Many BSRC initiatives were designed specifically for the early learning sector and early learning providers were involved in shaping the results. BSRC is recognised for expertise and experience in supporting service providers in their work on child health and development including a wide range of research related to parent education and engagement. This research has resulted in new parent materials, reports, strategies, learning events, etc. Initiatives involved varied research strategies including advisory groups, parent surveys, needs assessments, key informant interviews, focus groups, topic expert input, literature reviews, reviews of practice guidelines, etc., in order to develop approaches that were engaging, met needs and reflected current evidence.

Report

This report was developed to summarize the findings from a brief literature scan and a survey of service providers, identifying factors that contribute to effectiveness by theme. The report includes:

- Models that put the child's needs at the centre of services.
- Information about terminology related to putting the child's needs at the centre of services.

In order to balance completeness, usability, and the budget/timeframe, this is a brief report, including links to the research for additional insights.

Methods

Timing

This project took place over 2.5 months, starting November 15, 2016 and ending January 24, 2017.

Timelines and Activity Steps		
Activity	**Purpose**	**Date Completed**
Met with MCDC to discuss expectations	Clarification of expectations	November 17, 2016
Defined search phrases and research parameters	Search phrases and parameters	November 22, 2016
Conducted a search of Canada & US academic and grey literature from 2000-2016	Search results	December 22, 2016
Developed a draft report summarizing results	Draft report	January 16, 2017
Finalized report based on input from MCDC	Final report	January 24, 2017

Databases Searched

- ***Academic Literature:*** Peer reviewed articles were retrieved through:
    - PubMed: Includes more than 26 million citations for biomedical literature from MEDLINE, life science journals, and online books.
    - Scholars Portal: A digital repository of over 30 million scholarly articles drawn from journals covering every academic discipline.
    - "All" Proquest: A database of all Proquest databases such as Proquest Central, PsycARTICLES, PsychInfo, Social Services Abstracts, Sociological Abstracts, and more.
    - Canadian Best Practice Portal: A compilation of trusted and credible health promotion best practice information. No best practices used child and/or family centred language.
    - Cochrane Evidence: A database of systematic reviews of primary research in human health care and health policy. No reviews were found on the topics of interest.

- ***Grey Literature:*** The scan of grey literature focused on:
    - Google Scholar: A subset of the full Google search engine with search results derived from a variety of scholarly sources across many disciplines and sources, including articles, theses, books, abstracts, academic publishers, professional societies, online repositories, universities and other web sites.

- ***Articles from MCDC:*** In addition, MCDC forwarded some articles relevant to trauma-informed practices and these were included in the results.

Provincial Survey

In addition, BSRC developed an online survey of service providers regarding terminology related to services centred on the needs of the child. The survey was released in English through BSRC listservs to service providers working in maternal child health. Qualitative and quantitative results were summarized. See the Terminology Survey section for details.

Search Methods

The following search terms were used, with some variance based on criteria for searches of each database:

- Framework children needs
- Framework child centred/centered OR child and family centred/centered

Assessing Search Results

Searches were performed on author supplied titles. The results were sorted by relevancy (with those that were most relevant appearing first). As the number of search results per search phrase was often very high, only the top 100 most relevant search results were retrieved for each topic. Results were reviewed and articles that were relevant to the topics were retained. There was a focus on higher level results (e.g. systematic reviews rather than individual research projects or opinion articles). While the searches were limited to Canadian and US research from 2000-2016, some retained articles included information from beyond these geographic limitations. As we reviewed the results, we considered evidence and relevant discussion or focus related to the following topics:

- Frameworks focusing on putting the child at the centre
- Vulnerable/marginalized children/families/communities
- Terminology related to putting children/families at the centre
- Seamless services
- Voices of children
- Trauma-informed approaches

Definitions

In this report the term *provider* is used to describe the range of service providers who may be working with parents, children and families, for example registered early childhood educators, social workers, public health nurses, lay-home visitors, etc.

While there is significant diversity in the caregivers and families caring for children, the text in this report reflects the wording and populations studied in the research, for example, mothers and fathers.

Limitations

Activity steps for this project were based on roughly 6 days of work for BSRC and this limited the scope of the research for this project. The research was a scan of available information rather than a systematic review of the literature and in-depth analysis of results. Limitations included:

- ***Assessing the Evidence:*** The short timeframe permited only a brief scan of literature. Within the scope of this budget it was not possible for a full and detailed assessment of the credibility and research methods in each article. Instead, this report provides an overview of themes across retreived articles, with most focus on articles with the highest level of evidence, for example systematic reviews and articles from sources where the level of evidence had already been assessed, such as the Canadian Best Practice Portal.
- ***Number of Information Sources:*** In addition, the timeframe limited the number of sources that could be searched (see Databases Searched for details).
- ***Number of Search Phrases:*** To keep within budget and timeframe, a limited number of search terms was entered into each search engine or data source (see Search Terms for details).
- ***Sources:*** For efficiency we did not access the orignal articles refererred to in larger reviews. The end-notes refer content described in the accessed papers.
- ***Knowledge Gaps:*** In reviewing evidence regarding various models for services centred on the child, it is important to remember that the results only focus on interventions or components that have been intensively studied and have a solid evidence base. Other key models may not be listed because they have not been intensively reviewed, the results have not been published, or the information did not come up in our searches.
- ***Trends:*** Any trends identified in the literature will, of course, vary by individuals, families, communities, cultures, etc., for example understandings of child or family-centred services.

Frameworks that Put the Child at the Centre

Introduction

MCDC is interested in service frameworks that have a clear focus on the child's needs. The research only retrieved one framework related to services for children, where the child's needs are put at the centre.

Child-centred Framework for Early Learners

An emergent, standards-based child-centred framework for early learners[1] (younger than kindergarten) was developed to support state-wide American early learning curriculum content standards designed to better prepare young children for kindergarten. This preliminary framework was intended as an approach to planning and assessment to support the play-based curriculum and to help teachers make informed instructional decisions. The assessment results were used to guide teaching, identify concerns for individual children, and provide information to improve and guide interventions. The framework used children's interests in various topics, assessment to support planning, and integration with early learning content standards. Teachers complete the concept planner, and then use data related to the early learning content standards, developmental domains, and the questions/interests of children to determine how to stage the environment as children investigate the selected topic. While this is a US example of how early childhood professionals used assessment that supported a state-wide curriculum, there may be learnings that are relevant to MCDC regarding frameworks for a child-centred approach.

Vulnerable/Marginalized Populations

Introduction

Children and families are profoundly influenced by difficult life circumstances such as poverty and abuse. While the retrieved articles that focused on child and/family centred services routinely mentioned benefits to vulnerable and marginalized populations (see section on Literature Results: Terminology), only two frameworks of interest (see below) were retrieved in this brief scan of the literature that may be of interest to MCDC in aligning their framework to the needs of vulnerable/marginalized populations.

Family Resilience Practice Framework

Family resilience practice frameworks are considered to be valuable for services working with families facing serious life challenges.[2] This approach can assist with healing and recovery from crisis, trauma, and loss; navigating changes; thriving despite adversity; chronic conditions; and positive development of children in vulnerable communities. Family resilience is the ability of families to withstand and rebound from difficult life challenges. Family resilience frameworks are a systemic perspective on risk and resilience in the family as a unit, fostering adaptation of the family and its members in situations of adversity. Stressful life challenges influence the entire family, and the responses of family members affect the whole family. In times of crisis, supportive bonds and community resources can help families to cope. Key processes in family resilience fall into the broad categories of belief systems, organizational patterns, and communicating/problem solving. Each of these categories can be strengthened to help families effectively manage adversity.

Social Paediatrics

Learnings from social paediatrics initiatives may inform effective frameworks for vulnerable and marginalized populations with young children.[3] This approach was used in inner city neighbourhoods where a high proportion of children experienced adverse childhood events and entered school developmentally delayed. In order to foster access and reduce inequities, there must be a commitment to identifying and addressing inequities, including an understanding of the social, material and

organisational conditions that contribute to inequities. The concepts of community engagement, capacity building and partnership are relevant to improving services and meeting needs. The social paediatrics approach was designed to improve access to services and to ensure services were responsive to the health and developmental needs of children at risk due to social and material circumstances. An important component was outreach clinical services using a partnership approach (i.e. clinical services offered locally). Priorities included linking children and families with needed services including continuity of care, recognising adverse childhood events, and addressing the social determinants of health. Initiatives were designed to improve access to required services, streamline referrals, and address the social conditions that contributed to the concerns. Premises included:

- Providing local services.
- Recognising the importance of enduring supportive relationships.
- Believing in the competence of children, families and their communities.

Recommended Approaches

In addition to the frameworks mentioned above, to address the pervasive impacts of socio-economic status, recommended approaches include raising awareness, building provider skills, coordinating services, focusing on early intervention, teaching parenting skills, providing quality child care, meeting basic needs, and offering home visiting.[4]

Trauma-informed Approaches

Traumatic events for a child under the age of six include exposure to death, serious injury, sexual violence, or threats to the child or others. Our search results only retrieved a few articles that included trauma-informed approaches and these were brief mentions or largely irrelevant. As a result, the text in this section relies mainly on the articles provided by MCDC. While there are many similar models and contexts for trauma-informed approaches, the following are key components of a holistic approach to trauma-informed practice across an organization and can be incorporated into a service framework:

- **Establish Principles, Policies and Practices:** Trauma-informed policies and practices should be founded on principles of acknowledgement, safety, trust, collaboration, choice and control, empowerment, strengths and compassion, and must be supported by leadership.[5] [6] [7] Policies and procedures should also reflect the need for cultural competency, privacy and confidentiality, and safety.[8] They should be implemented across the organization for a whole organization approach.[9]

- **Provide Staff Training:** It is important for trauma-informed approaches to include training for all staff in the organization, not just the providers who work directly with children and families. Training should include: understanding the prevalence and impacts of trauma; recognising the signs, symptoms and triggers of trauma; avoiding re-traumatization; setting up a safe environment for those affected by trauma; and use of a range of effective approaches to address trauma.[10] [11] [12] [13] [14] There are materials available to support staff learning and change.[15]

- **Form Partnerships:** Connecting with other organizations in your community can strengthen referral networks for those impacted by trauma.[16]

- **Avoid Re-traumatization:** While services should be perceived as safe places with trusted in caring adults, it is difficult to actualize if children are responding fearfully to interventions or

incidents. For example, providers need to be sensitive to possible negative responses of children to certain procedures (e.g. fire alarms, immunizations, etc.) and the potential for re-traumatization.[17] Policies and services can be designed to reduce the risk of re-traumatization for children and families.[18] Important aspects to consider include the organization of services/space, provider attitudes, and service culture and interaction patterns.

A child psychiatric service adjusted its approaches[19] to minimize the risk of re-traumatization, moving from a focus on group norms, consistency, and control, to new values of nurturing, opportunities to learn and teach, and providing choices based on individual needs. They focused on collaboration between and among children and adults to solve problems, rather than enforcement of rules. This required staff training and changes in staff roles, as they became observers of behavior, teachers, role models, and collaborators. These changes resulted in reduced use of restraints and seclusion, incidence of staff injuries and staff turn-over. The specific trauma-informed approaches included:

- Staff members were expected to covey in a variety of ways that children were cared for, liked and valued.
- Medical procedures were not forced on children (see Literature Results: Voices of Children for examples). If a child refused a service, the provider tried to understand why the service was being refused and tried to resolve the situation in a way that met the needs of the child and the provider.

- **Plan Ahead:** Effective trauma-informed practices involve planning ahead in order to respond calmly and effectively if there is a traumatic event or if someone responds to trauma in their lives. This includes knowing effective in the moment responses, being aware of referral services, etc.[20]

- **Use Screens and Assessments:** Trauma screens and assessments can be used to learn more about the child's history and experiences. The results aid in selecting appropriate referrals and interventions.[21] Screening and assessment tools are available and staff training is required on the use of selected methods.

- **Provide Services for Children/Families Affected by Trauma:** Service delivery methods for those affected by trauma should be clearly identified, including screening, assessment, intervention, referral, etc. The following are key trauma-sensitive responses:[22]
  - Partnering with families.
  - Strengthen traumatised children's relationships with adults.
  - Helping children to modulate and self-regulate emotions and behaviors.
  - Enabling children to develop to their potential.
  - Using relationship-based practice.
  - Use of social and emotional education strategies (e.g. self-regulation).
  - Use of intensive intervention.

- **Support Providers:** Working with traumatized clients can have short and long-term negative impacts on providers. Supervision and supports must be in place to prevent, identify and address any symptoms of secondary trauma.[23] [24] This can include encouragement and supports for provider self-care and well-being.

- **Monitor and Evaluate:** Organizations can put processes in place to monitor and evaluate the use of trauma-informed practices, as well as possible traumatic events or responses.[25] Results can be used to strengthen the trauma-informed approaches.

Seamless Services

Children, especially those with special needs or facing other difficult live challenges, can benefit from a comprehensive continuum of care and services. Service delivery can be strengthened through service coordination and staff training.[26] Unfortunately, this brief scan of the literature did not retrieve any articles that mentioned specific frameworks, philosophies or strategies to provide seamless services, with the exception of the article on social paediatrics (see section on Social Paediatrics) and non-specific mentions of meeting the needs of children and/or families in discussions about use of child and/or family centred services (see section on Literature Results: Terminology).

Voices of Children

If services are truly to meet the needs of children, the voices of children need to be considered. There are challenges to hearing voices of children and in ensuring that their voices are reflected in service frameworks. Unfortunately, only a few of the articles retrieved in this this brief scan of the literature included specific mentions of how organizations accessed and included the voices of children.

Child-centred practices include focused efforts to meet the needs of children, in addition to working together with children, for example participation of children in decision-making and services.[27] The idea of giving children a voice and an opportunity to have a say on issues concerning themselves is still a fairly new concept and can be difficult to actualize while also meeting their needs. The concept involves both changes in values and changes in practices. While there has been considerable discussion about the importance of voices of children, there have been delays and practical challenges in realizing children's right to participation. One barrier is that providers can be concerned about what could happen if children had more influence on decisions concerning services. There are also questions about how to ensure services are hearing and responding to the perspectives of children.[28]

In an American early learning setting, a framework was developed where questions from children were used as a key way to select and develop activities to meet early learning curriculum standards (see section on Child-centred Framework for Early Learners).[29]

It can be difficult to consider the needs of the child in some situations, for example if a child opposes a needed service or practice. An article on shifts in child psychiatric care included some specific examples of how they managed to respect the voices of children in difficult situations, using trauma-informed approaches.[30] For children who were admitted to the unit and were fearful of going to bed at night, the unit had strategies available to help children settle including allowing children to sleep in the hall in view of staff if they wished, and allowing children to watch TV in their room until sleepy. They also had a protocol for needles that respected the wishes of children. For example an anesthetic cream was applied to the arm 30 minutes prior, and if a child refused due to fear, the test was postponed. Additional medication might be used to help make the procedure less painful. Rewards and praise were provided and individual requests were considered (such as having another child or a parent present). The advantages and disadvantages of medical procedures were weighed against the potential for re-traumatization. The clinical necessity of procedures was reviewed and other options were explored.

One article focused on the use of drawings in research on child-centred approaches[31] and this practice may be useful in ensuring the voices of children are heard at MCDC, despite young age or any difficulties with communication or literacy. Another paper discussed methods that can be used to ensure the voices of children with physical or cognitive challenges are captured. [32] Some examples of approaches to hearing the voices of children (including those with various challenges) include:

- Asking the child to draw a picture of a particular concept.
- Using drawings, pictures, photographs and props to eliciting responses.
- Having conversations centred on drawings, pictures or vignettes.
- Using focus groups or interviews with pairs of children.
- Engaging a child in casual conversation while participating in an activity with him or her.
- Having an advocate/ interpreter for the child.

Terminology that Puts the Child at the Centre
Literature Results

Introduction

The terminology discussed in this report reflects various aspects of services that put the child at the centre. These terms have been used in both universal services and services focused on specific priority populations. The term *child-centred* services clearly identifies a primary need to focus on and protect the child's interests. Terms that include the word family go further to reflect that children, for the most part, live in the context of their family, and acknowledge the important influence of families on children.

Child-centred Language

Definition

Child-centred refers to commitment to a primary focus on the needs of the child. Child-centred practices include working for children, in addition to working with children.[33] In implementing child-centred approaches, interactions with children are considered to be further supported by sensitive relationships with families.[34]

A discussion around child-centred approaches to early childhood practice[35] suggests that term *child-centred* has rich pedagogical associations that can include values related to individuality, child development and democracy. It notes that child-centred approaches are commonly associated with freedom, learning through play and developing activities in response to the interests of the child. A play-based approach enables providers to respond to the unique interests of every child. The three strands of child-centred practice, informed by an increasing understanding of how young children develop and the identification of the rights of the child, include:[36]

- A child is at the centre of their world (individuality of a child).
- A child is at the centre of their learning (child development).
- A child should direct her/his own learning (child rights).

The term *child-centred* is used differently in different countries.[37] Approaches can be needs-based and/or rights-based, and have varied implications for provision of services, protection of children, and participation of children in decision making and services. Canada, in general, has a needs-based approach, focusing more on respecting the needs and interests of a child, rather than protecting child rights.

Implementation
In the implementation of child-centred approaches, staff training is an important way to establish common purposes, intents, methods, outcomes and best practices.[38]

A paper[39] reflecting on the use of the term *child-centred* in terms of involvement of children in research, acknowledged that children can be active social agents who make choices and negotiate their social and intellectual pathways within the context of existing adult controls. This paper reflects on how child-centred research can be conducted, i.e. how to do research with children rather than on them. While the focus of the paper was research in older children, rather than services for young children, the following elements may be of interest to MCDC:

- **The child as the expert.** As adults we cannot know what it is like to be a child or to be a specific child. The world of a child is best explored by learning from children.
- **The child as a partner.** In order to place children at the centre, and recognise them as experts, meaningful partnerships must be developed. Services must be completed with children, not on them, and providers need to be able to listen to the views of children, and also act on these views.

Benefits
Child-centred terminology emphasizes and respects the primary importance of meeting the needs of children and their entitlement to be considered as persons of value and persons with rights.[40] The benefits of an interdisciplinary child-centred approach include advocacy for the child and access to and integration of services for better results for the child. For providers, there may be more satisfaction with services and less burn out. For organizations there can be paradigm shifts, and stronger mission, vision and practices.[41]

Limitations
The term *child-centred* does not refer to the important role of the family. It has been used in service delivery where the family was not actively involved, for example it was used to describe an assessment framework to support early learning curriculum standards[42] that was not inclusive of parents.

Use of the term *child-centred* may imply power and responsibility; however, while children may be considered social agents, adults (e.g. parents, child care providers, health care providers, etc.) frequently need to make decisions and actions on behalf of children.[43]

Differing cultural understandings of children and interpretations of child-rearing practices may make it difficult to achieve a common understanding of child-centred approaches in some services or with some families.[44]

Family-centred Language
Definition
The term *family-centred care* was introduced to the public over 50 years ago, to stress the importance of the family in children's well-being, and is now used broadly in services for children. Over time health care practices have moved from models of service delivery described as *medically-focused*, to *client-centred*, to *family-centred*. The changing terminology responded to the ecological theory of child development released in 1979, stressing the importance of immediate family, extended family and environment when working with children. In the past 30 years family has been increasingly included in child health care decision making and family-centred values and practices have been widely implemented in variety of settings. The shift from client-centred to family-centred services for adults

and children recognizes that families are a basic social unit and that clients need to be treated in the context of the family, in terms of supports, insights and challenges.[45]

While there are many different definitions of services that are *family-centred*, there is generally reference to aspects such as strengths-based, family-driven and focused, culturally-sensitivity, empowerment-focused, offering choices, and building partnerships.[46] Family-centred services aim to link families to a wider range of services, build on family strengths, emphasize family choice, engage families in their own community, and address barriers to services. Examples of family-centred service delivery approaches include wraparound care, family group conferencing and systems of care. Frameworks may include references to striving for cultural curiosity, honoring family wisdom, believing in possibilities, building on family resourcefulness, working in partnership with families, ensuring that services meet needs, empowerment and accountability to clients. This approach emphasizes that providers need to be partners in helping families improve their lives in supportive communities. Helpful components may include collaborative inquiry, client engagement, envisioning change, identifying barriers and facilitators, supporting clients, addressing barriers, increasing enablers, and making changes in the community.

One article[47] described family-centred principles as:

- Striving for cultural curiosity.
- Believing in resourcefulness.
- Working in partnership.
- Making our services accountable to the clients served.

An interdisciplinary conceptual framework for building family-centred policies and practices identifies that all family-centred policies and practices share the following features:[48]

1. Families are experts in what helps and hurts them.
2. Families are invaluable partners for policy makers, providers and advocates.
3. Families are not dependent clients. Providers and policy makers collaborate with and empower families and view them as equals.
4. Family-centred policies and practices promote systems of care and mutual support between families and within communities.
5. Family-centred policies and practices promote recognition of rights and gender equity.

Incorporating a Child-centred Approach

A family-centred approach must also incorporate a person-centred approach, starting with the child. Some key roles include:

- Acknowledging parents as partners in the care of their child.
- Providing the information, skills and resources needed to support family participation.
- Developing collaborative working relationships with the child.
- Recognising parents and family as equal partners.
- Incorporating a person-centred planning model to address the child's needs.
- Addressing the needs of siblings.
- Supporting the right of families to make choices.
- Identifying the resources needed to support the family.
- Providing information and skills so that families can make informed decisions.
- Empowering families to become advocates.
- Advocating for the families.
- Forming inter-disciplinary teams that include family members.

- Building in cultural competency.
- Respecting each family's uniqueness.[49]

Continuum of Models

While family-centred services have a lot in common across a wide-range of service delivery situations, there is a continuum of family-oriented program models including professionally-centred services, family-allied services, family-focused services, and family-centred services, each with its own set of beliefs and assumptions about families.[50] In professionally-centred services, providers are considered the experts, and treatment decisions are made by the professionals. This approach is becoming more infrequent. In the family-allied or family-guided model, professionals are viewed as experts and identify needed interventions, while families are enlisted and trained to implement these interventions. In the family-focused or family-directed model, providers identify service options and parents select from those options. In family-centred models, providers partner with families and families are considered to be capable of making informed choices and acting on their decisions in ways that address their child's needs and support and strengthen their family.

Implementation

Family-centred approaches need to take into account the family's stressors, strengths, perceptions, coping and adaptation strategies, when addressing family concerns or challenges.[51]

Benefits

Family-centred practices are used in development, delivery and evaluation of services to meet the needs of children. This strength-based approach recognizes families are central to children, recognises that families and children are unique, and acknowledges parents as the experts in their children's needs. Most importantly, this approach supports the family's role in decision-making about services for their child. Family-centred services may include opportunities for family-to-family support as well as supports for families so they can better care for and support their child.[52]

Family-centred care increases the involvement of families in planning and service delivery and as a result, family and service delivery is responsive to family choice and family priorities. It builds on the strengths of the family and their knowledge of the child. It is useful across all families, including those with special needs or challenges. Although family choice may not always be feasible, this approach is sensitive to family desires and does not expect or force families to align with all functions of services.[53]

Family-centred approaches were identified as important in working with children with special needs, such as attention-deficit/hyperactivity disorder. Important factors for consideration include parenting and parent-child relationships, parental cognitions, parental adjustment, marital interactions, general family relationships, and adaptive child functioning within the family.[54]

Services that were family-centred were found to differ from those that were led by professionals.[55] In professionally-centred programs, relational and participatory aspects of service provision were practiced less often, compared to other kinds of family-oriented programs. Family-centred services more frequently offered participatory practices that provided parents with choices/options and opportunities to be involved in solutions to problems and in learning needed knowledge and skills.

Family-centred service delivery has also been associated with lower levels of stress and higher levels of satisfaction in parents.[56]

Limitations
Families vary widely in functions, roles, members and the term family-centred may have a variety of interpretations and impacts for individual families, specific cultural groups and geographic areas. The interpretations and impacts of family-centred services may also vary by service type.[57]

Child and Family Centred Language
Definition
Child and family centred care is an approach to the planning, delivery, and evaluation of services grounded in partnerships between providers, children, and families. It is considered to be collaborative, respectful, and important to the provision of services for children. The interpretation and implementation of child and family centred care varies between services and between providers. *Child-centred* care is often considered to be a component of *child and family centred* care.[58]

Child and family centred care is based on the following principles:

- Practices that reflect dignity and respect.
- Sharing information in affirming and useful ways.
- Supporting families to build on their strengths.
- Collaboration between children, families and providers.[59]

Benefits
This type of service has been associated with increases in patient and family satisfaction, decreases child and parent anxiety, more rapid recovery from medical procedures, improved mental health of mothers of children with a chronic illness, and increased provider satisfaction.[60]

Limitations
Barriers to child and family centred care include:

- Lack of knowledge regarding the principles and practices.
- Lack of organizational support.
- Providers' perception it might threaten their professional identities.[61]

Terminology that Puts the Child at the Centre Survey Results

Survey Methods
An online survey of providers was conducted through Survey Monkey from December 16, 2016 to January 10, 2017. The invitation to participate in this online survey was distributed through BSRC listservs including the *Maternal Child Health Promotion Network* (2,710 recipients), the *Best Start Indigenous Sharing Circle* (983 recipients) and the *Healthy Babies Healthy Children listserv* (632 recipients). The majority of listserv participants were located in Ontario, with a small proportion from other provinces (12%) and other countries (1%). The invitation to the online survey was also forwarded to MCDC in case MCDC wanted to invite their contacts and networks to participate.

A total of 327 people started the survey. Respondents most commonly provided services to parents of young children (81%), young children (71%), pregnant women and their partners/families (65%), newborns (64%), couples preparing to have a baby (31%), and/or service providers (39%). The sectors represented by respondents included public health (46%), child and youth serving organizations (23%), medical services (9%), Indigenous organizations (7%), government (5%) and education (2%).

Responses to open-ended questions were scored based on identified themes and percentages were calculated. These percentages were based on the total number of scored responses, not on the number of respondents (i.e. respondent responses often scored for more than one theme).

Child-centred* versus *Child and Family Centred

The survey asked respondents whether they preferred the term *child-centred services* OR *child and family centred services* when describing services focused on the needs of the child. There were 327 responses to this question. Responses included:

- Preference for *child and family centred services* (78%)
- Preference for *child-centred services* (8%)
- Other (12%)

In the 40 responses under the *Other* category, the most common terms mentioned included:

- *Client-centred services* (5 responses)
- *Family-centred services* OR *family-centred care* (5 responses)

These results show a clear preference for *child and family centred services* over *child-centred services*.

Advantages and Disadvantages of the Term *Child-Centred*

Respondents were asked to identify any advantages or disadvantages to use of the term *child-centred services*. There were 142 responses to this question and many respondents presented more than one advantage/disadvantage in their response. The main themes (those with 4 or more scores) included:

Advantages

- Clear focus on the child and their needs (18%)

Disadvantages

- Does not include the important role of family and parents, not inclusive or holistic (59%)
- May only include services directed at children, for example daycare, swimming lessons, child protection, clinical care for children, or school (13%)
- Unclear about ages or appears to exclude age categories, for example prenatal, infant, youth (4%)

Responses mainly indicated concern that the term *child-centred* did not reflect the important role of the family.

Advantages and Disadvantages of the Term *Child and Family Centred*

Respondents were asked to identify any advantages or disadvantages to use of the term *child and family centred services*. There were 138 responses to this question and many respondents presented more than one advantage/disadvantage in their response. The main themes (those with 4 or more scores) included:

Advantages

- Includes important role of the family, inclusive, holistic (48%)
- Implies that there are services for children and services for families (16%)
- Includes all forms and members of families (3%)

Disadvantages

- It is a long term (5%)
- May exclude caregivers (e.g. foster parents, grandparents) or some families (e.g. single parent, LGBTQ, extended family) (5%)
- Takes the primary focus away from meeting needs of the child (5%)
- The term *family* already includes the child (5%)

Responses mainly indicated support for the term *child and family centred*, based on inclusion of the important role of the family.

Best Terminology to Describe Services that are Centred on the Child

At the end of the survey respondents were asked to identify the best terminology to reflect services centred on the needs of a child. There were 122 responses to this question and many respondents presented more than one term in their response.

The main themes (those with 4 or more scores) included:

Terminology that only included wording related to the child:

- *Child-centred services* (15%)
- *Child-focused services* (4%)
- *Child-centred care* (3%)
- *Services for children* OR *children's services* (3%)

Terminology that included wording related to the family:

- *Child and family-centred services* (33%)
- *Child and family services (18%)*
- *Family services (8%)*

While there were many variables and options suggested by respondents in response to this question, the results reflect most interest in the terms *child and family centred services* and *child and family services*.

Implications to MCDC

The results of this survey clearly indicate a preference for terminology related to *child and family centred services*, mainly because it includes the valuable role of the family. MCDC will need to reflect on this input, as well as input and context from other sources, in selecting the terminology that best works for MCDC.

Survey respondents were interested in the discussion and often eloquent and passionate in their responses. A few quotes of theme-related interest from the survey include:

- *"Children's issues don't exist in a vacuum."*
- *"You are not going to discuss breastfeeding support with a baby, or the importance of attachment with a baby, you are discussing it with their caregivers so the service can never be solely for the child. If I advertise myself as providing 'child-centred services' am I giving the impression that the parents aren't part of the team, and that I'm providing services for the child and excluding the parents from the care provider-client relationship?"*

- *"Child-centred services may lead families to assume that parents or other family members will not necessarily be considered in the provision of services."*
- *"A child exists in the context of family."*
- *"If the parents are not instructed or coached in the services the child receives, the effect is lessened. A Child and Family Centred Approach ensures the child has the benefit of parents that understand and buy-in to the child developmental piece."*

Within the survey responses there were a few isolated or uncommon responses that BSRC would like to draw to the attention of MCDC:

- Concern that the term selected is clearly differentiated from child protection services.
- Direction from Ministry of Education and OEYC/FC to use terminology related to *child and family services.*
- Comments about whether it is better to say *services* OR *supports* OR *focus.*
- Comments about whether to use *centred* OR *focused.*
- Comments about whether it is better to say *client* instead of *child* or *child and family.*
- Comments about whether it is better to say *family,* rather than *child and family,* as the child is part of the family.
- Comments about whether to use *health* OR *health and development* rather than *services* (for example provided was *child health and development* or *family health*).
- Comments about using *early learning* OR *early years* wording instead of *child* OR *child and family.*

References

[1] Baldwin JL, Adams SM, Kelly MK. (2009). Science at the center: An emergent, standards-cased, child-centered framework for early learners. *Early Childhood Educ J*, *37*, 71–77. Retrieved from: http://journals2.scholarsportal.info/details/10823301/v37i0001/71_satcaescffel.xml

[2] Walsh F. (2012). Community-based practice applications of a family resilience framework. D.S. Becvar (ed.), *Handbook of Family Resilience*, p. 65-82. Springer Science+Business Media, New York. Retrieved from: http://link.springer.com/chapter/10.1007%2F978-1-4614-3917-2_5

[3] Lynam MJ, et al. (2010). Social paediatrics: creating organisational processes and practices to foster health care access for children 'at risk'. *Journal of Research in Nursing*, *15*(4), 349–350. Retrieved from: http://journals2.scholarsportal.info/details/17449871/v15i0004/349_rspcophcafcr.xml

[4] Lieberman AF & Osofsky JD. (2009). Poverty, trauma and infant mental health. *Zero to Three*, *30*(2), 54-58. Retrieved from: https://eric.ed.gov/?id=EJ915186

[5] Wolf MR, Green SA, Nochajski TH, Mendel WE, Kusmaul N. (2014). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research, 40*, 111–120. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/01488376.2013.845131?af=R&

[6] Wolf MR, Green SA, Nochajski TH, Mendel WE, Kusmaul N. (2014). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research*, *40*, 111–120. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/01488376.2013.845131?af=R&

[7] Dym Bartlett J et al. (2015). Trauma-informed care in the Massachusetts Child Trauma Project. *Child Maltreatment*, *21*(2), 101-112. Retrieved from: http://www.traumacenter.org/products/pdf_files/TIC_MassChildTraumaProject_B0005.pdf

[8] Klinic Community Health Centre. (2013). *Trauma-informed: The trauma toolkit*. Retrieved from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

[9] Dwyer J, O'Keefe J, Scott P, Wilson L. (2012). *Literature review – a trauma-sensitive approach for children aged 0-8years*. Australian Government Department of Families, Community Services and Indigenous Affairs. Retrieved from: http://www.whealth.com.au/documents/work/trauma/LiteratureReview.pdf

[10] Cronn S & Iversen B. (2013). *Essential trauma informed practices in schools*. Arizona Department of Education School Safety and Prevention. Retrieved from: http://www.azed.gov/prevention-programs/files/2013/12/trauma-informed-schools-barb-iversen.pdf

[11] Wolf MR, Green SA, Nochajski TH, Mendel WE, Kusmaul N. (2014). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research*, *40*, 111–120. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/01488376.2013.845131?af=R&

[12] Thomas B, Scott B, Pooler DK. (2015). Increasing the use of trauma-sensitive lens for school case managers: A training assessment. *Journal of Adolescent and Family Health*, *7*(1), Article 4. Retrieved from: http://scholar.utc.edu/jafh/vol7/iss1/4/?utm_source=scholar.utc.edu%2Fjafh%2Fvol7%2Fiss1%2F4&utm_medium=PDF&utm_campaign=PDFCoverPages

[13] Dwyer J, O'Keefe J, Scott P, Wilson L. (2012). *Literature review – a trauma-sensitive approach for children aged 0-8years*. Australian Government Department of Families, Community Services and Indigenous Affairs. Retrieved from: http://www.whealth.com.au/documents/work/trauma/LiteratureReview.pdf

[14] Dym Bartlett J et al. (2015). Trauma-informed care in the Massachusetts Child Trauma Project. *Child Maltreatment*, *21*(2), 101-112. Retrieved from: http://www.traumacenter.org/products/pdf_files/TIC_MassChildTraumaProject_B0005.pdf

[15] Klinic Community Health Centre. (2013). *Trauma-informed: The trauma toolkit*. Retrieved from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

[16] Dym Bartlett J et al. (2015). Trauma-informed care in the Massachusetts Child Trauma Project. *Child Maltreatment*, *21*(2), 101-112. Retrieved from: http://www.traumacenter.org/products/pdf_files/TIC_MassChildTraumaProject_B0005.pdf

[17] Regan KM, Curtin C, Vorderer L. (2006). Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*(1), 29–40. Retrieved from: http://journals2.scholarsportal.info/details/10736077/v19i0001/29_psiipccacafc.xml

[18] Dwyer J, O'Keefe J, Scott P, Wilson L. (2012). *Literature review – a trauma-sensitive approach for children aged 0-8years*. Australian Government Department of Families, Community Services and Indigenous Affairs. Retrieved from: http://www.whealth.com.au/documents/work/trauma/LiteratureReview.pdf

[19] Regan KM, Curtin C, Vorderer L. (2006). Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*(1), 29–40. Retrieved from: http://journals2.scholarsportal.info/details/10736077/v19i0001/29_psiipccacafc.xml

[20] Cronn S & Iversen B. (2013). *Essential trauma informed practices in schools*. Arizona Department of Education School Safety and Prevention. Retrieved from: http://www.azed.gov/prevention-programs/files/2013/12/trauma-informed-schools-barb-iversen.pdf

[21] Thomas B, Scott B, Pooler DK. (2015). Increasing the use of trauma-sensitive lens for school case managers: A training assessment. *Journal of Adolescent and Family Health*, *7*(1), Article 4. Retrieved from: http://scholar.utc.edu/jafh/vol7/iss1/4/?utm_source=scholar.utc.edu%2Fjafh%2Fvol7%2Fiss1%2F4&utm_medium=PDF&utm_campaign=PDFCoverPages

[22] Dwyer J, O'Keefe J, Scott P, Wilson L. (2012). *Literature review – a trauma-sensitive approach for children aged 0-8 years*. Australian Government Department of Families, Community Services and Indigenous Affairs. Retrieved from: http://www.whealth.com.au/documents/work/trauma/LiteratureReview.pdf

[23] Wolf MR, Green SA, Nochajski TH, Mendel WE, Kusmaul N. (2014). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research*, *40*, 111–120. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/01488376.2013.845131?af=R&

[24] Dwyer J, O'Keefe J, Scott P, Wilson L. (2012). *Literature review – a trauma-sensitive approach for children aged 0-8years*. Australian Government Department of Families, Community Services and Indigenous Affairs. Retrieved from: http://www.whealth.com.au/documents/work/trauma/LiteratureReview.pdf

[25] Dym Bartlett J et al. (2015). Trauma-informed care in the Massachusetts Child Trauma Project. *Child Maltreatment*, *21*(2), 101-112. Retrieved from: http://www.traumacenter.org/products/pdf_files/TIC_MassChildTraumaProject_B0005.pdf

[26] Lieberman AF & Osofsky JD. (2009). Poverty, trauma and infant mental health. *Zero to Three*, *30*(2), 54-58. Retrieved from: https://eric.ed.gov/?id=EJ915186

[27] Rasmusson B, Hyvönen U, Nygren L, Khoo E. (2010). Child-centered social work practice — three unique meanings in the context of looking after children and the assessment framework in Australia, Canada and Sweden. *Children and Youth Services Review*, *32*(3), 452–459. Retrieved from: http://www.sciencedirect.com/science/article/pii/S0190740909003107

[28] Merriman B & Guerin S. (2006). Using children's drawings as data in child-centred research. *The Irish Journal of Psychology*, *27*(1-2), 48-57. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/03033910.2006.10446227

[29] Baldwin JL, Adams SM, Kelly MK. (2009). Science at the center: An emergent, standards-based, child-centered framework for early learners. *Early Childhood Educ J*, *37*, 71–77. Retrieved from: http://journals2.scholarsportal.info/details/10823301/v37i0001/71_satcaescffel.xml

[30] Regan KM, Curtin C, Vorderer L. (2006). Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*(1), 29–40. Retrieved from: http://journals2.scholarsportal.info/details/10736077/v19i0001/29_psiipccacafc.xml

[31] Merriman B & Guerin S. (2006). Using children's drawings as data in child-centred research. *The Irish Journal of Psychology*, *27*(1-2), 48-57. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/03033910.2006.10446227

[32] Whyte J. (2006). Giving a voice to children with disabilities. *The Irish Journal of Psychology, 27*(1-2), 16-26. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/03033910.2006.10446224

[33] Rasmusson B, Hyvönen U, Nygren L, Khoo E. (2010). Child-centered social work practice — three unique meanings in the context of looking after children and the assessment framework in Australia, Canada and Sweden. *Children and Youth Services Review*, *32*(3), 452–459. Retrieved from: http://www.sciencedirect.com/science/article/pii/S0190740909003107

[34] Georgeson J, Campbell-Barr V, Bakosi E, Nemes M, Pálfi S, Sorzio P. (2015). Can we have an international approach to child-centred early childhood practice? *Early Child Development and Care*, *185*(11-12), 1862-1879. Retrieved from: http://www.tandfonline.com/doi/full/10.1080/03004430.2015.1028388

[35] Georgeson J, Campbell-Barr V, Bakosi E, Nemes M, Pálfi S, Sorzio P. (2015). Can we have an international approach to child-centred early childhood practice? *Early Child Development and Care*, *185*(11-12), 1862-1879. Retrieved from: http://www.tandfonline.com/doi/full/10.1080/03004430.2015.1028388

[36] Chung S & Walsh DJ. (2000). Unpacking child-centredness: A history of meanings. *Journal of Curriculum Studies*, *32*(2), 215–234. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/002202700182727

[37] Rasmusson B, Hyvönen U, Nygren L, Khoo E. (2010). Child-centered social work practice — three unique meanings in the context of looking after children and the assessment framework in Australia, Canada and Sweden. *Children and Youth Services Review*, *32*(3), 452–459. Retrieved from: http://www.sciencedirect.com/science/article/pii/S0190740909003107

[38] Rasmusson B, Hyvönen U, Nygren L, Khoo E. (2010). Child-centered social work practice — three unique meanings in the context of looking after children and the assessment framework in Australia, Canada and Sweden. *Children and Youth Services Review*, *32*(3), 452–459. Retrieved from: http://www.sciencedirect.com/science/article/pii/S0190740909003107

[39] Emond R. (2006). Reflections of a researcher on the use of a child-centred approach. *The Irish Journal of Psychology*, *27*(1-2), 97-104. Retrieved from: http://journals2.scholarsportal.info/details/03033910/v27i1-2/97_roarotuoaca.xml

[40] Merriman B & Guerin S. (2006). Using children's drawings as data in child-centred research. *The Irish Journal of Psychology*, *27*(1-2), 48-57. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/03033910.2006.10446227

[41] Steinberg AG, Bennett Woodhouse B, Burrell Cowan A. (2002). Child-centered, vertically structured, and interdisciplinary: An integrative approach to children's policy, practice, and research. *Fam. Ct. Rev*, *40*(1), 116-134. Retrieved from: http://journals2.scholarsportal.info/details/15312445/v40i0001/116_cvsaiatcppar.xml

[42] Baldwin JL, Adams SM, Kelly MK. (2009). Science at the center: An emergent, standards-based, child-centered framework for early learners. *Early Childhood Educ J*, *37*, 71–77. Retrieved from: http://journals2.scholarsportal.info/details/10823301/v37i0001/71_satcaescffel.xml

[43] Emond R. (2006). Reflections of a researcher on the use of a child-centred approach. *The Irish Journal of Psychology*, *27*(1-2), 97-104. Retrieved from: http://journals2.scholarsportal.info/details/03033910/v27i1-2/97_roarotuoaca.xml

[44] Georgeson J, Campbell-Barr V, Bakosi E, Nemes M, Pálfi S, Sorzio P. (2015). Can we have an international approach to child-centred early childhood practice? *Early Child Development and Care*, *185*(11-12), 1862-1879. Retrieved from: http://www.tandfonline.com/doi/full/10.1080/03004430.2015.1028388

[45] Bamm EL & Rosenbaum P. (2008). Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Arch Phys Med Rehabil*, *89(*8), 1618–1624. Retrieved from: http://www.archives-pmr.org/article/S0003-9993(08)00308-0/abstract?cc=y=

[46] Madsen WC. (2009). Collaborative Helping: A Practice framework for Family-Centered Services. *Fam Proc, 48*, 103–116. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1111/j.1545-5300.2009.01270.x/full

[47] Madsen WC. (2009). Collaborative Helping: A practice framework for family-centered services. *Fam Proc, 48*, 103–116. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1111/j.1545-5300.2009.01270.x/full

[48] Briar-Lawson K, Lawson HA, Hennon CB, Jones AR. (2001). *Family centered policies and practices: international implications*. p. 185-6. New York: Columbia Univ Pr. As cited in Bamm EL & Rosenbaum P. (2008). Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Arch Phys Med Rehabil*, *89(*8), 1618–1624. Retrieved from: http://www.archives-pmr.org/article/S0003-9993(08)00308-0/abstract?cc=y=

[49] Strock-Lynskey D & Keller DW. (2007). Integrating a family-centered approach into social work practice with families of children and adolescents with disabilities. *Journal of Social Work in Disability & Rehabilitation*, *6*(1-2), 111-134. Retrieved from: http://www.tandfonline.com/doi/abs/10.1300/J198v06n01_07

[50] Dunst CJ, Boyd K, Trivette CM, Hamby DW. (2002). Family-oriented program models and professional helpgiving practices. *Family Relations*, *51*(3), 221-229. Retrieved from: http://www.jstor.org/stable/3700138?seq=1#page_scan_tab_contents

[51] Bamm EL & Rosenbaum P. (2008). Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Arch Phys Med Rehabil*, *89(*8), 1618–1624. Retrieved from: http://www.archives-pmr.org/article/S0003-9993(08)00308-0/abstract?cc=y=

[52] Bamm EL & Rosenbaum P. (2008). Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Arch Phys Med Rehabil*, *89(*8), 1618–1624. Retrieved from: http://www.archives-pmr.org/article/S0003-9993(08)00308-0/abstract?cc=y=

[53] Strock-Lynskey D & Keller DW. (2007). Integrating a family-centered approach into social work practice with families of children and adolescents with disabilities. *Journal of Social Work in Disability & Rehabilitation*, *6*(1-2), 111-134. Retrieved from: http://www.tandfonline.com/doi/abs/10.1300/J198v06n01_07

[54] Cunningham CE. (2007). A family-centered approach to planning and measuring the outcome of interventions for children with Attention-Deficit/Hyperactivity Disorder. *Journal of Pediatric Psychology*, *32*(6), 676–694. Retrieved from: http://journals2.scholarsportal.info/details/01468693/v32i0006/676_afatpaifcwad.xml

[55] Dunst CJ, Boyd K, Trivette CM, Hamby DW. (2002). Family-oriented program models and professional helpgiving practices. *Family Relations*, *51*(3), 221-229. Retrieved from: http://www.jstor.org/stable/3700138?seq=1#page_scan_tab_contents

[56] Bamm EL & Rosenbaum P. (2008). Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Arch Phys Med Rehabil*, *89(*8), 1618–1624. Retrieved from: http://www.archives-pmr.org/article/S0003-9993(08)00308-0/abstract?cc=y=

[57] Bamm EL & Rosenbaum P. (2008). Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Arch Phys Med Rehabil*, *89(*8), 1618–1624. Retrieved from: http://www.archives-pmr.org/article/S0003-9993(08)00308-0/abstract?cc=y=

[58] Regan KM, Curtin C, Vorderer L. (2006). Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*(1), 29–40. Retrieved from: http://journals2.scholarsportal.info/details/10736077/v19i0001/29_psiipccacafc.xml

[59] Regan KM, Curtin C, Vorderer L. (2006). Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*(1), 29–40. Retrieved from: http://journals2.scholarsportal.info/details/10736077/v19i0001/29_psiipccacafc.xml

[60] Regan KM, Curtin C, Vorderer L. (2006). Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*(1), 29–40. Retrieved from: http://journals2.scholarsportal.info/details/10736077/v19i0001/29_psiipccacafc.xml

[61] Regan KM, Curtin C, Vorderer L. (2006). Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*(1), 29–40. Retrieved from: http://journals2.scholarsportal.info/details/10736077/v19i0001/29_psiipccacafc.xml