

Parent-Professional Partnerships in Young Children's Care and Education in the United States and Brazil

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Abstract

There is increasing evidence that the most promising practices in intervening with young children at risk for adverse developmental outcomes include respectful partnerships between professionals and children's families. Often referred to as the family-centered system of care, this approach has been incorporated into policy both in the United States and Brazil. This paper focuses on outlining historical changes in young children's care and education in these two societies, changes in the views of child care and the importance of socio-emotional development, and the key elements of meaningful professional-family partnerships. It also presents a set of necessary conditions to translate the family-centered system's principles and research findings into practice.

Keywords: Mental health; government policy making; emotional development.

Parcerias entre Profissionais e Famílias no Atendimento a Crianças Pequenas nos Estados Unidos e no Brasil

Resumo

Há cada vez mais evidências de que as intervenções mais promissoras com crianças pequenas que correm o risco de apresentar atrasos no desenvolvimento incluem o estabelecimento de respeitadas parcerias entre os profissionais e as famílias das crianças. Esta abordagem, frequentemente denominada sistema de cuidado centrado na família, tem sido incorporada às políticas públicas nos Estados Unidos e no Brasil. Este artigo descreve brevemente transformações históricas no cuidado e educação de crianças pequenas nestas duas sociedades, mudanças nas concepções de cuidado da criança e a importância do desenvolvimento sócio-emocional e elementos-chave de parcerias significativas entre profissionais e família. Além disso, apresenta um conjunto de condições necessárias para implementar, na prática, resultados de pesquisa e os princípios do sistema de cuidado centrado na família.

Palavras-chave: Saúde mental; política governamental; desenvolvimento emocional.

Young Children's Care and Education: Historical Developments

An overview of the policies dealing with the care and education of young children in the United States and Brazil shows that, in the nineteenth century, in the two societies, the care and education of young children was seen as the family's basic duty (Howard, Williams, Port, & Lepper, 2001; Kuhlmann, 1998; Montenegro, 2001; Scarr & Weinberg, 1986; Tobin, Wu, & Davidson, 1989). Thus when both parents had to work in order to provide enough for themselves and their children, the parents were considered either incapable of raising their children or in some way *pathological* (Howard et al., 2001). Some child-care services were therefore established to look after these children and to address their basic needs (for example, food, protection,

and cleanliness) while their parents were working. At almost the same time, nursery schools were established in order to provide education and socialization of young children of wealthy families. However, in both cases, children were viewed as "the product of parent's competence and attention" (Howard et al., 2001, p. 56).

During the course of the twentieth century a transformation occurred in the conceptions of care and education in early childhood. This transformation was neither rapid nor homogeneous; in the course of the last 100 years different visions of caring for the young co-existed. For example, in the United States, "until 1965, the Federal Children's Bureau still held the position that day care would be disruptive for healthy family relations and that it should be provided only to those families who were not capable of providing adequate care for their children" (Howard, 2001, p. 65). In Brazil, until 1988, with the promulgation of a new constitution (and following complementary legislation), services for children from birth were not considered as a right of the children themselves and of their families (Vasconcellos, Aquino, & Lobo, 2003). In both countries, the differences between services for the poor and for the rich established in the nineteenth century lasted for a long time. For the children of the working classes, the services were primarily those of providing basic care (*e.g.*, feeding, cleaning, and keeping them safe during the day); for those of wealthy families, they were above all concerned with the education and socialization of children.

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By the beginning of the twenty-first century, however, conceptions about young children's early care and education had changed in both countries. Services for young children (even for children of the poor) are increasingly considered as a complement of the socialization provided by the family. Partial evidence for this is the fact that many more children are in child-care centers or preschools than the number expected based solely on the numbers of mothers who work. For example, in the United States, according to the National Institute for Early Education Research (2003), "(...) increased maternal employment is only one part of the explanation for increased enrollments" in early childhood programs (p. 7). Most children spend time in a preschool prior to five years of age regardless of the labor-force status of their mothers. Similar trends are evident in Brazil. In 2003, 1.2 million Brazilian children were in day nurseries and another 5.6 million in preschools (Instituto Nacional de Estudos e Pesquisas Educacionais Anísio Teixeira, 2004). This means that approximately 9% of children from birth to three years of age attended day nurseries and about 56% of children from four to six years of age attended preschools (Instituto Brasileiro de Geografia e Estatística, 2000). However, neither the availability of child care nor the uniformity of its quality is close to being a reality in either country.

Young Children's Mental Health: The Importance of Socio-Emotional Development

With the change in child care policies over the past decades have come an increasing focus on providing ways to support children's development in both the United States and Brazil. With this increased emphasis comes a greater appreciation of the importance of socio-emotional development for young children's well-being, with particular attention paid to those children who are having difficulty in this area. Researchers have consistently demonstrated that the first years of life provide the basis for healthy development in its various dimensions (*i.e.*, cognitive, emotional, social, and moral) and that if children's early needs are not properly met, serious difficulties may result.

Early child development can be seriously compromised by social, regulatory, and emotional impairments. Indeed, young children are capable of deep and lasting sadness, grief, and disorganization in response to trauma, loss, and early personal rejection. (Shonkoff & Phillips, 2000, p. 5).

Moreover, it makes more sense to intervene earlier rather than later. As Raver (2002) pointed out "one development axiom is that intervention early in the course of development is more cost-effective than later treatment for children and their families" (p. 10). Studies consistently show that as many as 50% of young children with serious social and emotional challenges will continue to have difficulties that not only persist but may get worse if left untreated (Neary & Eyberg, 2002; Webster-Stratton, 1998).

In the United States, the Surgeon General's Report on Child's Mental Health (U.S. Department of Health and Human Services,

1999) as well as the existing literature (see Campbell, 2002; Lopez, Tarullo, Forness, & Boyce, 2000) have reported that approximately 10 to 15 percent of young children have mental health challenges serious enough to require services. For children in poverty, the rate may be two to three times as great (Qi & Kaiser, 2003). In Brazil, while there are not enough data about young children's mental health problems, existing epidemiological studies suggest that the prevalence of behavioral problems in young Brazilian children may be even higher (24%) (Anselmi, Piccinini, Barros, & Lopes, 2004) probably due to increase in number of children in poverty. As Penn (2002) suggested, global economic policies that contribute to growing impoverishment in many countries greatly affect children. In 2000, 48.6% of Brazilian children under six years of age have parents who earn less than twice the minimum salary, the currently accepted standard of poverty (IBGE, 2000).

Promising Practices in Young Children's Mental Health

Given that early intervention is helpful in changing the likely trajectories of these children presenting mental health problems, what type of intervention is likely to prove most beneficial? The research literature has identified the following common factors that characterize those interventions that are most likely to lead to success (Simpson, Jivanjee, Koroloff, Doerfler, & García, 2001).

First, services should be community-based, working through the primary adults in the child life and in the environments where children live and play. All too often, mental health services are provided only at a clinic and involve only the child and the therapist. These practices do not take into account the critical nature of the context in which the behavior develops and is maintained.

Because young children are so dependent on parents and other caregivers, changes in their caretaking environments are often necessary to bring about changes in the child. Thus, particularly with regard to services for young children, for any improvements to be maintained and generalized to home and school, the child's family, peers, day care providers, etc. must be active participants in creating a therapeutic environment.

This participation must go beyond the caregivers merely carrying out the therapists' recommendations. There must be true collaboration between professionals and families with services being delivered in a family-centered philosophy. Family members should be involved with professionals in designing, implementing, and evaluating services.

While it seems quite evident that interventions should be developmentally appropriate, all too often, interventions are based solely on reducing negative behaviors and are not focused on functional goals of those skills and behaviors that the child needs to develop in order to reach developmental expectations. Awareness of age-appropriate behavior, alongside the particular needs and strengths of the child, can help providers offer appropriate supports and services to the child and the family.

Along with a focus on developmentally appropriate behaviors, interventions that build on strengths are more likely to be successful. Interventions are more likely to be perceived

as positive when services are designed to improve the socio-emotional health of the child in all settings in which he or she is situated and the well-being of his or her entire family. Service providers should pay particular attention to the needs, strengths, and culture of the families with which they are working.

For children and families who have serious needs, they are often involved with multiple agencies since no one agency or discipline can meet the diverse, complex, and changing needs of young children and their families. However, unless there is some attention to coordinating these services, even evidence based practices may not be as effective as possible because of the lack of coordination and the tendency to overwhelm families and children. Systems that encourage interagency collaboration are more likely to result in the effective use of multiple providers.

Parents: From Patients to Partners

Ideas about best practice when dealing with young children's early mental health issues have therefore come to include the view that parents need to have a key role in the solution to their children's problems – but in partnership with professionals. This approach have been incorporated into agency policy (*e.g.*, Maternal Child Health Bureau, Division of Service for Children with Special Health Needs, in the United States, and Special Education Guidelines, in Brazil), into federal law (Individuals with Disabilities Education Act, IDEA, in the United States), and recently into policy recommendations by the American Academy of Pediatrics (2003).

However, putting these policies into practice at the local level has not been easy. In part this is due to historical factors. As was clear from our brief historical overview, in both societies parents were considered to have the sole responsibility for children's socialization, and children's development was therefore the result of parent's competence or in cases where the child was having difficulty, a result of the

parent's incompetence. Still to this day, parents continue to be blamed for their children's problems. Single mothers, parents without obvious means of supporting themselves, parents believed to have mental difficulties (particularly mothers with depression), and mothers who apparently do not care sufficiently about their children's development have all been cited by professionals as the root causes for children's difficulties (Alexander & Dore, 1999; Campbell, 2002; Johnson et al., 2000, 2003; Scheper-Hughes, 1992). Given this suspicion on the part of professionals, it also is not surprising that parents have not placed much trust in professionals. Nonetheless, there is increasing evidence that the most promising practices in intervening with young children with special care needs include those in which parents are considered less as patients than as partners. Table 1 illustrates some differences between these two approaches.

One of the common barriers in implementing family-centered care frequently expressed by professionals is "That's fine for some families but not for the families I work with." These concerns have been raised in reference to families who may be at risk for abusing or neglecting their children (Barton, 2000), caregivers with mental retardation or who have serious mental illness, teen parents, and parents of lower socioeconomic status (DeGangi, Wietlisbach, Poisson, Stein, & Royeen, 1994; Harry, 2002). Some scholars have also been concerned about situations in which it is assumed that caregivers will be overwhelmed and not able to think clearly (*e.g.*, during the death of a child; during resuscitation attempts; during invasive medical procedures; in the emergency department) (Baucher, Waring, & Vinci, 1991; Knapp & Mulligan-Smith, 2005; Meyers et al., 2000). Despite these assumptions, research data indicate that families who are treated as a respected partner in their child's care are more likely to be satisfied with the care (Gerkenmeyer & Austin, 2005), less likely to feel stressed, more likely to continue to be an active participant, and more likely to evidence an increase in self-

Table 1
Differences Between Professional-Centered and Family-Centered Approaches in Young Children's Mental Health

Patterns of relationship	Professionals → Parents	Professionals ↔ Parents
Parents' role	Patients - Parents are viewed as being responsible for their child's mental health problems and recipients of treatment.	Partners - Parents are viewed as having knowledge about their child and being capable of making decisions about or carrying out the treatment of their child.
Professionals' role	Experts - Professionals are considered as experts with the unique knowledge about the child's needs and should use their professional expertise to fix presenting problems.	Members of the team - Professionals use their expertise taking into account the experiences, needs, hopes, and desires of the individual child and his/her parents as partners with parents.
Assessment and treatment	Deficit oriented - Problems, which are conceptualized as residing in the child (or the family), are focused upon and addressed.	Strength based - The intervention aims to strengthen parents in their roles as nurturers and providers in order to yield optimal child developmental outcomes using existing strengths to address concerns.

efficacy and empowerment. There are also data that there are improved child outcomes (Dempsey & Dunst, 2004) with family empowerment mediating the link between fidelity to family-centered care practices and improved child outcomes (Rogers & Shelton, 2005). These findings have been reported across health and mental health settings, across socioeconomic strata and across cultures.

Clearly, these particular situations do make professionals feel nervous about using a family-centered care approach. However, in reality, if the parent or caregiver is healthy enough for the child to be still in their care, then they are the primary decision maker, have an important role in the implementation of any planning, and need to have their values, beliefs, and wishes considered. Not involving the parent who has a mental health challenge or some other characteristic that may make professionals uncomfortable in the decision making process does not do away with the challenge. In fact, one could argue that these families are the very ones that we should be reaching out to try to forge a true partnership. These are real challenges and what is needed is preservice and inservice training for professionals around these challenging situations. The benefits of partnering with all families far outweigh the worries of professionals.

According to Osher and Osher (2002), this paradigm shift is in response to the poor outcomes of children who were dealt with in this more traditional approach. Findings in the fields of developmental disabilities, mental health care, and health care indicate that collaborative partnerships between professionals and families leads to better outcomes for children, families, and staff (Dunst, Trivette, & Jodry, 1997; Fox, Vaughn, Wyatt, & Dunlap, 2002; Shelton, 1994; Shelton & Stepanek, 1994). Another influence in the development of more appropriate models of care has been the increased visibility of systemic theories of development, particularly those that show the mutual influences of children, parents and other caregivers, and the cultural community (Dunst, 2000; Guralnick, 1997; Lerner, Rothbaum, Boulos, & Castellino, 2002; Turnbull, Blue-Banning, Turbiville, & Park, 1999). Systemic models of development, particularly Bronfenbrenner's theory (Bronfenbrenner, 1979, 1993), are increasingly well known in Brazil (Alves et al., 2002; Ceconello & Koller, 2000; Lisboa et al., 2002; Tudge et al., 2000; Yunes, 2003). However, there is little evidence that this theory has had impact on Brazilian models of care for young children (Bhering & De Nez, 2002; Franco & Bastos, 2002).

The apparent dichotomy of approaches suggested by Table 1 is belied by research showing that, at the practical level, there is a continuum from programs that are not family-oriented at all to programs that are actually family-centered. The different degrees of *family-centeredness* are due to the fact that the set of principles, values, and beliefs characterizing professional-parent partnerships has not always been consistently translated into practice. For example, the participatory components of helping practices (*i.e.*, those that provide parents with opportunities to be

actively involved in decisions and to acquire knowledge and skills that strengthen family functioning) are less common than the relational aspects of helping practices (*i.e.*, practices associated with good clinical skills and professional beliefs about parents' capabilities, especially related with parenting competence). Furthermore, practices vary among different types of programs and among professionals (Dunst, 2002; Dunst, Boyd, Trivette, & Hamby, 2002).

Beyond Policy: Lessons from the Field

Despite the recent changes in agency policies, federal laws, policy recommendations, and findings on effectiveness mentioned above, research on professional practices suggests that the family-centered approach is neither universally adopted nor easily implemented in either the United States or Brazil (Bhering & De Nez, 2002; Bruder, 2000). Although in Brazil some scholars have only recently underlined the importance of establishing partnerships between professionals and parents to care and educate young children, in the United States this idea is not new. The concept of family-centered care was first formalized into a set of principles to guide policy and practice for children with special health care needs in the 1980s (Shelton, Jeppson, & Johnson, 1987). Although much is also needed in the United States, the advancements made since this publication highlight the *evolutionary* nature of this approach (American Academy of Pediatrics, 2003; Shelton & Stepanek, 1994). As our understanding of families, of young children mental health, and of professional expertise continues to develop, it should be clear that there can be no single *achievement* of a perfect system of family-centered care. Instead, we should be working continually to improve the quality of partnerships among families, children, and services.

Part of the challenge has been to operationalize the often abstract philosophical principles of family-centered care into concrete core competences. In both Brazil and the United States, scholars have been making strides to achieve this. In Brazil calls have been made to build collaborative relationships among teachers, multidisciplinary professionals, and parents and to make services work across agency lines in order to care and educate children with special needs (Paulon, Freitas & Pinho, 2005). In the United States, Walker, Koroloff, and Schutte (2003) have proposed a set of conditions that to be evident at the direct provider, the agency, and the policy levels to implement family-centered care programs: 1) Professionals and other team members must be able to use specific techniques and procedures for shared decision making, defining and prioritizing goals, obtaining feedback, ensuring family centeredness, building on strengths, participating collaboratively, resolving conflicts, identifying effective and high quality providers; 2) Agencies have to chose a practice model and provide professionals, parents, and other team members with opportunities to learn this model and to share knowledge and experience. Ongoing support is as important as initial training; 3) Strengths-based practice can best be fostered

within organizations that take a strengths-based view of staff; 4) Positive outcomes for professionals and for agencies are associated with building partnerships with organizations that also support family-centered care values; 5) Even when a common plan format is not in place, agencies must work together to avoid the lack of consistency across plans of different agencies; 6) Administrators have to avoid overloading workers in order to reduce burnout. Building the sense of team among workers is an important factor to avoid turnover among professionals and other team members; 7) Availability and a clear philosophy about funding required to meet families' unique needs are very helpful for both agency members and community; 8) Leaders in the policy and funding context play an important role in recognizing and rewarding services that implement evidence-based practices. Without support from these leaders family-centered care programs can be implemented in isolated groups for a short period of time. They should also advocate for flexible funding strategies; 9) Policy and funding leaders have to provide incentives for the implementation of interagency cooperation and they play a key problem-solving role across agency boundaries; 10) The model of *continuous improvement* requires well-designed and documented plans and permanent review of goals, actions, and indicators of progress at team, organization, and system levels.

These ten recommendations have clear implications for professional training with providers needing training and support to engage in true partnerships with families and with professionals from other disciplines and across other agencies. While increasing in number, many preservice training programs do not provide specific instruction in these family-centered skills and it may be difficult for service providers to find the time to gain these skills through inservice training. As important to individual provider skills development is for the agency to create an environment that is supportive of these practices. This includes building family-centered practices into job descriptions and raises, creating flexible funding streams, demonstrating a commitment to work out conflicting recommendations among professionals, and an appreciation that evaluation is key to quality improvement. Monitoring not only family and staff satisfaction but also child developmental outcomes are key to effective interventions.

Final Considerations

The history of early childhood policies in the United States and Brazil suggests that the emergence of the family-centered approach can be understood as a part of changes in conceptualizing children and families that occurred over the course of the twentieth century. However, research findings indicate that these new ideas have not been easily translated into practice in either society. Highlighting the conditions that should be considered to implement family-centered care programs, we hope to have fostered further advances in the practice of partnerships and, therefore, to improve young children's well-being.

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