The importance of early home-based guidance (EHBG) for hearing-impaired children and their families in Flanders

G. Lichtert1,2 and A. van Wieringen1

1KU Leuven: ExpORL, Dept Neurosciences, 2KOCA: Dept Home Guidance Jonghelinckshof

Key-words. Deafness; early intervention; home-based guidance; newborn hearing screening

Abstract. The importance of early home-based guidance (EHBG) for hearing-impaired children and their families in Flanders. This state-of-the-art report describes the rationale and evidence for family-centred early intervention after newborn hearing screening (NHS). More specifically, we document the organisation and practice of early home-based guidance (EHBG) in Flanders, as well as the new challenges and paradigm shifts induced by NHS. Since the introduction of NHS, the number of participants with bilateral hearing loss entering one of the five EHBG centres in Flanders (one in each of the region’s provinces) before the age of twelve months has doubled. About half of the screened population receive EHBG and about 80% of them do so before the age of six months. However, there is enormous variation between the different provinces and this has still to be clarified.

Introduction

Exactly half a century ago, the importance of early home-based guidance (EHBG) for families and children with a hearing loss detected early was clearly underlined by Wendy Galbraith at the twelfth international congress on education of the deaf in Washington DC in 1963.1 This was the first time, since those congresses had first been organised in 1878, that the role of the parents in education for the deaf had been addressed at this important international forum.

Wendy Galbraith, who worked as an educational consultant in London, found that congenitally deaf children traced by the age of six to nine months (the earliest target ages for screening at that time) should, like hearing children, learn their language and speech at home. She therefore argued that education for these very young children should start with the education of the adults and siblings at home.1

Although thinking about the roles of parents and counsellors has changed over time, the idea that parents have to be empowered to raise a child with a significant hearing loss is still gaining importance in the new era of universal newborn hearing screening (UNHS).

Fortunately, the importance of this approach was clearly understood by Kind & Gezin (Child & Family) when they launched their UNHS programme in Flanders in 1998. From the beginning, Kind & Gezin decided to link their programme to multi-disciplinary diagnosis, audiological support, multi-disciplinary rehabilitation and early home-based guidance.2

This paper includes a state-of-the-art report relating to the rationale and evidence for family-centred early intervention (FCEI). More specifically, we will explore the organisational structure and new challenges for early home-based guidance (EHBG) in Flanders since the introduction of UNHS.

The rationale for family-centred early intervention (FCEI)

Why has working with parents at home become so important and why are we continuing to move away from residential care for the deaf child and from stand-alone child-centred rehabilitation programmes?

The rationale for FCEI is not difficult to understand and it has certainly been triggered by newborn hearing screening (NHS). NHS allows that babies receive care a few weeks or months after birth. Every service provider will understand immediately the thinking of the famous paediatrician and psychologist Donald Winnicott, who stated as long as twenty years ago that there are no babies, there are only parent-baby dyads. A baby is an
existential part of a relationship. Without a caring adult, a baby will never survive on its own.3,4

“I like to assume that if we see a baby we also see environmental provision, and behind this we see the mother.”3,4

It is not surprising that this close bond can be seriously harmed by the shock triggered by the child’s deafness, especially when the parents themselves are not deaf. It seems unnatural, and even unethical, to work with a baby in the absence of a principal caregiver. The reasoning behind FCEI is also clear when one considers the moment of diagnosis. When a child is diagnosed as deaf shortly after birth, the parents change immediately, but not the child. There is no immediate change in the child’s perception of the world on the day the diagnosis is made. By contrast, the bottom often falls out of the parents’ world.

“When she was diagnosed as being deaf, everything changed. Her husband, Stephen, also noted changes in the family system as a whole; as he stated, deafness has completely changed one of the major focuses of our family.”

The consequence is that the world of the child will also change rapidly as a result of the shift in the educational perspective and the transformation of communicative interaction between the child and the caregivers. By its very nature, deafness is never an isolated phenomenon affecting a single person. It is a communicative issue par excellence, and therefore always interwoven with the child’s entire interactional context. The logical consequence is that the family should be involved as a full partner in the habilitation process from the very beginning. This is certainly the case in 90% of families where both parents are hearing and have no experience in dealing with deafness when their child is diagnosed.

Involving parents as full partners from the beginning in the rehabilitation process also fits in with the modern concept of disability as defined by the ICF model (International Classification of Functioning) of the World Health Organization (WHO).4 The ICF, which has been adopted as the conceptual framework for the world report on disability, understands functioning and disability as a dynamic interaction between health conditions and contextual factors, both personal and environmental.4 This means that “disability” is created by the functioning of the person in his natural environment. The better the interaction between the person with his necessary context, the more restricted the disability. This means that limiting rehabilitation programmes to individual therapy for children outside the educational context would conflict with the current ICF disability model.

Furthermore, the Joint Committee on Infant Hearing subscribes, in its Year 2000 and Year 2007 Position Statements,8,9 to the importance of FCEI.

“Early intervention professionals provide comprehensive family centred services. They are professionals trained in a variety of academic disciplines, such as speech-language pathology, audiology, education of children who are hard of hearing and deaf, service coordination, early childhood special education.”8

The same committee also argues in favour of a partnership model as the best model for successful early detection and intervention.

“The success of EHDI (early hearing detection and intervention) programs depends on professionals working in partnership with families as a well coordinated team.”8

The nature, and multidisciplinary character, of early home-based guidance in Flanders means that these conditions are endorsed and implemented.10 In the 2007 JCIH position statement updates, the JCIH recommends the provision of both home-based and centre-based intervention options.9

Scientific evidence for FCEI and EHBG

Impact studies of interventions at home are scarce but they do exist. These empirical studies are not very feasible, not only because of the large number of variables but also for ethical reasons. We know of at least four studies indicating that family-centred early intervention for children with developmental, hearing and speech language disabilities has a significant effect.

The best methodological controlled study is Gibbard’s.11 Her study consisted of two well-controlled experiments in children with language delay. These experiments show that the therapeutic effect on language development in very young children is similar for children whose families received family-oriented advice and support in 11 sessions over a period of 6 months and for the children who were given individual rehabilitation for 1 hour a week over a period of 6 months in a rehabilitation centre. The results were significantly different in a
control group of children on a waiting list for rehabilitation during the same period and a group of children who received more general developmental stimulation but no specific language stimulation programme at home in 11 sessions over a period of six months. Mahoney et al. investigated the development of 600 children with developmental disorders who participated in four early-intervention studies. The results showed that the children achieved a higher level of development when the responsiveness of the mothers in the interaction with their child was increased. Parent responsiveness is considered to be an important factor for both language development and socio-emotional well-being. More specifically in relation to deafness, Pat Moeller has found a significant effect of early intervention and family involvement in the language acquisition of children with a hearing problem. Holzinger et al. has shown that the early commencement of family-centred intervention significantly impacts language outcomes in children with hearing loss, as opposed to age at diagnosis and age at fitting of hearing aids.

The benefits of UNHS and early intervention for the language development of children with a significant hearing loss have been well documented worldwide. Studies in Flanders – see van Kerschaver for a review – have also demonstrated the benefits of early intervention. At present, there have been no effect studies measuring the impact of EHBG on the development of hearing-impaired children in Flanders. However, some studies in Flanders have found some evidence of need. Due to the UNHS and the early provision of appropriate hearing aids and cochlear implants, the interaction patterns between hearing parents and deaf children have changed. In a comparative study of deaf toddlers aged 18 months, Lichtert found that mothers of NHS children looked significantly less at their child than the mothers of non-NHS-children of the same age during a play situation with stacking blocks. They did look with the same frequency as parents with a hearing child of the same age. Although mutual gazing between parents and children did not differ significantly between the NHS condition and the non-NHS condition, it remains questionable whether this parental adaptation supports the communicative needs of the child. In the study by Vanormelingen et al., mothers of implanted children tended to react more to utterances of their child at an earlier stage of language development and less at later stages than mothers of hearing children. These authors suggest that parents should be encouraged by a speech language pathologist not to slacken their attention to the language development of their child. In another longitudinal Flemish study by Mouvet et al. looking at one child with a CI, the child seemed to benefit from a bimodal/bilingual approach to communication up to 9 months of age. However, a setback was seen in the child’s language development, and this was mirrored by a setback in the mother’s sensitive behaviour as she switched to a more monolingual approach after cochlear implantation. All these studies used video micro-analysis and showed that it is useful to support parents by introducing language-facilitating strategies at an early stage of communicative development. EHBG creates unique opportunities to achieve this goal.

In addition to this evidence demonstrating the effectiveness of family-based interventions for the quality of communicative interaction and language development in children, there is also research showing that parents themselves actually need this guidance. Zaidman-Zait concluded, in her research looking at the quality of life of parents with a child with a CI, that “parenting-related stress” is the single most important variable affecting parental satisfaction with their lives, not “child-related problems” such as those associated with the CI device itself, the audiological evaluation or the rehabilitation programme. Parenting-related stress is linked to parenting problems such as school choices, punishments and rewards, challenging but not spoiling, seeking balance in the family with other siblings and so on. This is also confirmed by research from various countries. Family-based early intervention programmes focus on all these areas. The study by Inger and Dromi also shows that both parents and professionals want an even stronger family-centred orientation, although this component was already ranked as above-average in their early intervention programme.

Organisation and aims of EHBG in Flanders

Flanders has a long tradition of EHBG. At present, there are five home-based guidance centres for families and children with hearing disabilities, one in each province. EHBG has the longest tradition in the education of the deaf compared with other disabilities. Long before the government made EHBG
a legal requirement, the institutes for the deaf organised an early intervention programme at home. Teachers of the Deaf (ToD) were convinced that the earlier a child could be fitted with hearing aids and trained, the better the learning results would be. Until the present time, the five home-based guidance centres for the deaf have continued to be part of more wide-ranging service centres which were originally linked with a school for the deaf in each province. These wider-ranging centres are seen as centres of expertise for the deaf. In addition to home guidance, they provide specific education, peripatetic education, rehabilitation, a boarding school service, audiological services and sometimes inclusive day-care services for babies and toddlers.

The belief that children should be helped as early as possible and that parents should be seen as the first and most important educators of their children was reflected in a government decree in 1988. This provides the legal basis for home-based care for children with a disability and their families. Since then, a lot of things have changed in both the working model and the organisational structure. The overall aim, however, has remained the same:

“Home guidance is a form of assistance which aims to provide educational support to families with a disabled child or a disabled adult, focused on the acceptance of disability on the handling and / or educating of the person with a disability and on the forward-looking orientation, so the development is encouraged and the family situation is supported.”

(This section is translated from the Belgian Official Gazette.)

At present, EHBG is still focused on the development of the child and educational and psychosocial support for the parents. Access to EHBG is quite straightforward with a prescription from an ENT doctor. Guidance is provided most of the time at home but it can also be organised for a small percentage in the guidance centre itself. Although EHBG is multidisciplinary by nature, a permanent home guidance interventionist is typically assigned to each family. The frequency of visits is determined in consultation with the parents. The frequency may change depending on the age and progress of the child and the needs of the family. Parents pay a small contribution determined by the government. An individual family service plan is developed for each family. Home guidance services are allowed to work together with a wide range of other care units such as medical, audiological and rehabilitation services. This is important to guarantee the best multidisciplinary services for each individual deaf child and the family.

**EHBG in practice**

EHBG uses different methods to achieve its targets. Most of the aims are accomplished by home visits. Some services use video feedback or parent groups. They may also contact parents or work with deaf role models. Video analysis and video home training have proven useful for parental guidance. This approach makes it possible to focus on the parents’ and the child’s communicative development, as well as the success of their mutual communicative interactions, in a more objective way. From experience we know that this approach is often more effective than modelled interaction in the real-life situation. It is also known from research that parents appreciate the opportunity to exchange emotions and experiences with other parents. When a child is diagnosed as deaf, this often results in changes in the parents’ social network. When parents are grieving and feeling sad, it is possible that they will lose some friends. Interaction with the wider family may also be affected. Expanding one’s network to include other parents of deaf children can therefore be very important, especially when it is not easy to discuss these problems within the existing network.

As well as providing mutual psychological support, parents can also give each other practical information about ways of coping with minor day-to-day problems.

**New challenges and changes in EHBG due to UNHS**

To establish a picture of the impact of UNHS in terms of the number of participants with a bilateral hearing loss in EHBG in Flanders, numbers of
participants were collected from home-based guidance centres in Flanders for every five-year period starting in 1997. This was one year before UNHS was implemented in Flanders. Data collection was limited to the first year of life because research had shown the tremendous importance of starting FCEI as soon as possible after diagnosis.

It was hypothesised that, in general, more children and families would join an EHBG programme at an earlier age after the introduction of UNHS than before. It was also expected that the number of families and children participating in an EHBG programme as a proportion of the estimated prevalence of hearing loss and birth rate in every province would be the same in the five provinces of Flanders.

The estimated number of potential children and families that could be participating in EHBG was calculated using the birth rates and the prevalence of hearing loss documented in the annual reports of Kind & Gezin for the different years.28,29,30 The prevalence of a persistent bilateral hearing loss of more than 40 dB was calculated by Kind & Gezin as being between 1 and 1.4 per 1000 screened neonates in the reports from 2001 and 200228 and between 1 and 1.5 per 1000 in the reports for 2009-2011.31,32 These figures do not include the children screened in the neonatal intensive care units. The birth rate for 2011 was used to make an estimate for 2012 because the figures of 2012 were not yet available.

**Number of participants in EHBG before 12 months**

Table 1 shows that there was a gradual increase in the total number of children and families participating in EHBG in the five centres in Flanders. Since UNHS was implemented in Flanders, the number of children and families receiving EHBG before the age of 12 months has doubled. Before UNHS was introduced, the estimated percentage of participants ranged from 22% to 31% of the potential participants; after the introduction of UNHS, the range was estimated to be between 45% and 69% for the five home-based guidance centres as a whole for the three target years under study.

Figure 1, however, shows enormous variation between the different services in Flanders. There is also variation within each province for the different years under research. For Figure 1, the estimated proportion of the participants before the age of 12 months was calculated based on the minimum prevalence of 1/1000 neonates. This means that the percentages would be lower if the prevalence had been estimated on the basis of 1.4/1000 or more.

Limburg and Oost-Vlaanderen (East-Flanders) seem to have the highest number of participants in EHBG. In a comparison of the different years studied, the highest level of variation seems to be in West-Vlaanderen (West-Flanders). The percentages for some regions are in excess of 100% because the prevalence of hearing loss was calculated using the minimum of 1/1000.

**Detailed analyses**

The Joint Committee on Infant Hearing recommends, in its Year 2000 and Year 2007 Position Statements,8,9 important milestones for early intervention to maximise linguistic competence and literacy development for children who are deaf or hard of hearing. Comprehensive audiological evaluation

<table>
<thead>
<tr>
<th></th>
<th>1997</th>
<th>2002</th>
<th>2007</th>
<th>2012a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antwerp</td>
<td>3</td>
<td>(18-26)</td>
<td>4</td>
<td>(17-24)</td>
</tr>
<tr>
<td>West Flanders</td>
<td>3</td>
<td>(12-17)</td>
<td>4</td>
<td>(11-15)</td>
</tr>
<tr>
<td>East Flanders</td>
<td>7</td>
<td>(15-21)</td>
<td>18</td>
<td>(14-19)</td>
</tr>
<tr>
<td>Limburg</td>
<td>3</td>
<td>(09-12)</td>
<td>9</td>
<td>(08-11)</td>
</tr>
<tr>
<td>Flemish Brabant</td>
<td>4</td>
<td>(11-15)</td>
<td>3</td>
<td>(10-15)</td>
</tr>
<tr>
<td><strong>Total N (estimated N)</strong></td>
<td><strong>20</strong></td>
<td><strong>(65-91)</strong></td>
<td><strong>38</strong></td>
<td><strong>(60-84)</strong></td>
</tr>
</tbody>
</table>
should take place no later than 3 months after birth, and appropriate intervention from health-care and education professionals with expertise in hearing loss and deafness should be provided by 6 months of age or less. This means that EHBG should start before the age of 6 months.

The detailed data from three of the five home-based guidance centres, Antwerpen (Antwerp), West-Vlaanderen and Limburg) made it possible to break down the numbers of participants in EHBG into age categories of three months.

Figure 2 shows that, after UNHS was introduced in Flanders, most children entering EHBG during the first year of life were aged 0-3 months. The numbers entering the programme gradually decreased in every subsequent period of three months. Before UNHS, the pattern was the opposite.

Looking at the entire group of children for the years 2002, 2007 and 2012 from Antwerpen, West-Vlaanderen and Limburg, 81% of the participants in EHBG were aged 6 months or younger. About half the participants (48%) were aged 3 months or less when they started EHBG. Although these figures do not look too bad, it should be pointed out that the number of the children and families who started to receive EHBG during the first year of life amounted to 42% and 59% of the potential candidates calculated on the basis of the birth rates in the provinces in the different years and a prevalence of 1 or 1.4 per thousand. Broadly speaking, it can be said that, in Flanders, about half of the screened population receives EHBG and that about 80% of them are doing so before the age of 6 months. However, we have to keep in mind that these figures are calculated for three of the five centres and that there is enormous variation between the different provinces.

A paradigm shift from a parent-initiated model of diagnosis to an institution-initiated model

As a result of UNHS, the diagnosis of hearing loss is now made much earlier than in the recent past. Rather than months or even years after birth, it is now a case of only weeks or even days. More than ever before, the early diagnosis of deafness is usually a bolt from the blue. It often comes as a real shock, making the family more vulnerable. Kurtzer-White and Luterman argue that parental coping has changed with the inception of newborn screening. In the period before NHS, mothers were usually the first people to be worried about the hearing of their child; nowadays, the diagnosis is as unexpected for mothers as for anybody else. The move from a parent-initiated model of diagnosis to an institution-initiated model involves new coping problems. In addition, the time frame has changed dramatically. Coping now begins without any preparation, and without any time for parents to “enjoy” their child as “normal”. Kurtzer-White and Luterman also argue that the grief models based on the death experience that are usually used to describe parental reactions to the diagnosis may also be inappropriate.
The importance of early home-based guidance (EHBG)

“There is not sufficient research on the long-term effects of chronic grief and how that impacts on parent-child bonding. There is evidence that our screening endeavors have far outstripped our habilitation efforts, leaving parents with a diagnosis but without support. This gap must be closed.”

Scarce scientific research shows that, although an overwhelming majority of parents want their child to be diagnosed very early, shock and emotional reactions have not diminished with UNHS. Another effect of UNHS is that babies with mild and unilateral hearing loss can also be identified at a very early age. Magnuson and Hergils conducted in-depth interviews with parents about NHS and found that parents whose children had a unilateral, mild hearing impairment with no need for intervention found the hearing screening to be problematic and would have liked to have been given more information.

Helping parents to cope with their grief is one of the important aims of EHBG. It was identified as an important aim from the very outset, when home guidance was recognised as a specific type of care by the Flemish government 25 years ago. The home guidance services in Flanders have also developed guidelines for parents of children with mild and unilateral hearing loss. Since 2011, home-based guidance centres are also allowed to work with children with unilateral and minor hearing losses. The regulations about the package, and the time span, for delivering services are still changing slightly but, at the moment, they seem to be adequate to empower parents so that they can act as good advocates for their child, give it the best possible chances in life and set up a follow-up route (medical, audiological and educational) for the future of their child.

A paradigm shift: from an expert model to a partnership model

Early intervention in deaf children must take place in the first instance with, and mainly through, the primary caregivers in the form of communicative interactions between the caregiver and the child in daily routines like feeding, bathing, diapering in the natural educational context. The quality of the intervention should not be measured using standardised tests for the child alone but mainly in terms of the involvement of the family. How are individual families involved in creating the necessary language acquisition base to support their children in their communicative and socio-emotional development?

From the view of medical rehabilitation thinking, treatment focuses on providing hearing aids and on training auditory and, most often, oral-verbal language skills that may be hampered in their development by the auditory disability. These skills are often trained individually but paramedics, mainly speech language pathologists, can also provide training, sometimes in smaller groups. The focus will be on training and compensating for deficits in the child. The working model is mainly an expert model. Parents are, most of the time, informed only about the objectives of the therapist and the progress the child has made after training. In some cases, parents are encouraged to become the co-therapists for their child and to train some elements from the therapy sessions in everyday situations at home.

In FCEI the emphasis is initially placed on the child’s primary caregivers and on the broader life context that includes day-care mothers, grand-parents etc. who take also care of the very young child from the very beginning. The FCEI working model is not an expert model but a partnership model in which professionals and the parents and caregivers work together as equal partners. In a partnership model, parents are seen as the experts on their own child with the capacity to support their child in the acquisition of the mother tongue during daily, natural routines. They are thought to have the necessary skills to create a basic climate that will ensure balanced social and emotional development. However, due to the diagnosis of deafness in children at an early age, parents often find it difficult to intuitively establish an ecological and powerful natural language-learning environment. Home-based guidance can play an important role in helping parents to re-establish this linguistic ecological environment and to recover their qualitative emotional availability. The language of children who are deaf or hard of hearing seems to be more responsive to greater maternal sensitivity. Most hearing parents are unfamiliar with deafness and Deaf culture, and it is therefore important for them to be informed about, and have access to, learning sign language or simultaneous communication (SimCom) if they wish to do so. The JCIH
recommends, when parents decide in favour of sign language, access to professionals with native or fluent skills in sign language who are trained to teach parents/families and young children. Families should also have access to professionals/individuals in a variety of different roles who are themselves deaf or Deaf.

The comprehensive guidance required by Kind en Gezin addresses, in a professional way, both the rehabilitative aspects of child support and the empowering of primary caretakers to provide a language-acquisition context. Establishing a tailored basic communicative language-acquisition climate in the family is the basis for good therapeutic intervention. Without this basic environment, which also includes the educational qualities of emotional availability (responsiveness, structures...), the therapy (audiology, speech therapy) will be less effective than one might expect. It is important to realise that a real language context is required to acquire a native language, not just a therapeutic setting.42

Both necessary factors – the individual rehabilitation of the child and the empowerment of the parents to establish a language-supporting environment – can be best guaranteed in Flanders by close collaboration between rehabilitation centres and home-based guidance services. This cooperation is supported by the government. Consequently, another important recommendation of the Joint Committee on Infant Hearing complies with the 2007 position statement in which the JCIH argues, in response to a previous emphasis on “natural environments,” that both home-based and centre-based intervention options should be on offer.9

The paradigm shift from an expert model to a partnership model also has an impact on the changing role of the home counsellor. During their visits, home counsellors can perform different functions. Mary Pat Moeller43 lists six different roles.

– Information resource: It is important for professionals to share information in a manageable and objective way so that families become independent advocates and learners. It is also important to help parents to reflect critically about their own reading input. The task of home-based guidance is to help parents make informed choices. Parents have to make important choices very soon after the diagnosis of deafness. Should their child receive a cochlear implant or not, what is the best communication mode for the child and the family, what are the best educational surroundings (day-care mother, crèche, inclusive day care) etc.?

– Coach role: In this role the parent is in the driver’s seat with the coach sitting behind her/him (in the ‘expert model’, the reverse is true). The clinician uses skills such as observation, well-timed input and outcome analysis to support and guide the interaction.

– Joint discoverer: Moeller et al.44 describe this as the key ingredient in a partnership model. Instead of telling parents what they have to do, home counsellors can formulate their ideas as experiments. The counsellors may say, “I wonder whether he would look at you if you imitated his sounds during play”. In this case we let the parent take the initiative – and the credit if it works. This is sure to boost parents’ confidence in themselves if the strategy proves to be successful. If the counsellor provides the model, parents may think that they are not able to be successful in the same way.

– News commentator: The ‘news commentator’ role involves providing objective descriptive feedback about key behaviours. This strategy highlights what works well with a given family.

– Partner in play: Sometimes the home counsellor will want to demonstrate a new skill. This will, however, only empower the parents if they are immediately given the opportunity to try it out for themselves and find out, through their own hands-on experience, that it works.

– Joint reflector and planner: After a home visit it is important to look back with the parents on ‘what we learned today’. What worked and what didn’t? This brings ongoing concerns into focus, and sets the agenda for the next session together.

Challenges and recommendations

In this paper, we described the rationale underlying EHBG and FCEI and explained the paradigm shifts and changing roles of EHBG as induced by UNHS. Preliminary data about the participants in EHBG shows that, in Flanders, about half of the screened population with a persistent bilateral hearing loss participate in EHBG and that about 80% of them do so before the age of 6 months. There is, however, significant variation between the provinces. These differences may be due to differences in service provision in each province but also to differences in the way parents are informed after UNHS44 or the
The importance of early home-based guidance (EHBG)

way UNHS is performed. It is important for the sensitivity and specificity of the screening instrument to be as high as possible to guarantee a transparent treatment programme. Further research is certainly needed to determine whether better access to these services is desirable and how it could be optimised. It is important for parents to receive complete and unbiased information about all aspects of service provision. An unbiased central referral admission point is probably necessary.

Although highly qualified professionals from different backgrounds are working in EHBG in Flanders, there is still no specialist and mandatory certification for home guidance interventionists based on a national accredited training programme. Research in a European context to study the competences of early interventionists and the possibilities for training programmes would seem to be very important.

The EHBG centres in Flanders are also challenged to cope with the demands of a rapidly-changing multicultural society. Work still has to be done to comply with the recommendations of the JCIII to build on strengths, informed choices, and the cultural beliefs of every family.

References


Guido Lichtert
Katholieke Universiteit Leuven
Herestraat 49, bus 721
3000 Leuven, Belgie
E-mail: guido.lichtert@med.kuleuven.be