A Comparison of the Individualized Education Plan and the Individualized Family Service Plan

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The individualized education plan (IEP) and the individualized family service plan (IFSP) are mandated for children with special needs. Occupational therapists participate in the development of both the IEP and the IFSP. This paper summarizes the similarities and the differences in the mandated components. The components addressed are (a) information about the child's status, (b) information about the family, (c) outcomes for the child and family, (d) intervention services, (e) other services, (f) dates and duration of services, (g) selection of a case manager, and (h) transition plans.

Development of the IEP and IFSP

The mandated components of the IEP and the IFSP have similarities and differences. Both require that a team develop the plans on the basis of available assessment information (Bailey, 1989; McGonigel & Garland, 1988); be tailored to each child's special needs (Bailey et al., 1986; Krauss, 1990; Smith, 1988); and include the parents (Krauss, 1990; Mallory, 1981; McGonigel & Garland, 1988; Turnbull & Turnbull, 1982). (See Table 1 for a more detailed comparison.)

Information About the Child's Status

The IEP includes statements about the child's present educational performance. The IFSP includes the present level of development in five areas: (a) physical development, (b) cognitive development, (c) language and speech development, (d) psychosocial development, and (e) self-help skills. In addition, the IFSP must include a statement on vision, hearing, and health status, as these often affect the function of other areas (see Table 1). Although these areas are frequently assessed in older children, their inclusion is not mandated on the IEP un-
Table 1
A Comparison of the Components of the Individualized Education Plan (IEP) and the Individualized Family Service Plan (IFSP)

<table>
<thead>
<tr>
<th>IEP</th>
<th>IFSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s present level of educational performance.</td>
<td>Infant’s or toddler’s level of physical development.</td>
</tr>
<tr>
<td>No provision for the family.</td>
<td>With the concurrence of the family, inclusion of a statement of the family’s strengths and needs related to enhancing the development of the child.</td>
</tr>
<tr>
<td>Annual goals, including short-term instruction objectives.</td>
<td>Annual outcomes expected for the child and family and their criteria, procedures, and time lines</td>
</tr>
<tr>
<td>Specific special education and related services necessary to meet the child’s needs and the family to achieve the outcomes identified.</td>
<td>Specific early intervention services necessary to meet the unique needs of the child and the family and to determine the extent to which the child and family are achieving the outcomes.</td>
</tr>
<tr>
<td>No provision for inclusion of other services necessary to meet the child’s needs.</td>
<td>Statement of other medical services necessary to meet the child’s needs.</td>
</tr>
<tr>
<td>Projected dates for initiation of services and the anticipated duration of services.</td>
<td>Projected dates for initiation of services and the anticipated duration of services.</td>
</tr>
<tr>
<td>Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional objectives are being achieved.</td>
<td>Criteria, procedures, and time lines to determine, on at least a semiannual basis, the degree of progress toward achieving the outcomes identified and whether modifications or revisions of outcomes are necessary.</td>
</tr>
<tr>
<td>No provision.</td>
<td>The name of the case manager from the profession most immediately relevant to the child’s or family’s needs.</td>
</tr>
<tr>
<td>No provision.</td>
<td>Steps to be taken to support the transition of the child from the infant-toddler program to a preschool program upon reaching age 3 years.</td>
</tr>
</tbody>
</table>

Note: Both the IEP and the IFSP are covered in the Individuals With Disabilities Education Act Revisions of 1991 (Public Law 102–119).

Interpretation of the data in Table 1 indicates that less emphasis may be placed on the child’s educational performance if they interfere with the child’s educational performance. Specific standards for documentation of the level of physical development in the IFSP are not furnished. However, Bailey (1988) recommended stating the child’s strengths as well as his or her needs, emphasizing functional abilities rather than the test score, putting ability in a developmental context, describing ability in all relevant developmental domains, including less traditional child-related information such as behavior characteristics, and describing functional limitations of the child relevant to intervention planning. For example, development of gross and fine motor skills is integral to early intervention in occupational therapy. Stating that the infant is functioning at a given age level does not provide information about the quality of the response, adaptations of the response, or the infant’s behavior during the response. Information about the quality or adaptation of the response better describes the infant’s functional abilities and should therefore be included in the IFSP (Bailey, 1988).

Information About the Family

Traditionally, the family has participated to varying degrees in the development of the IEP (McGonigal & Garland, 1988). Turnbull and Turnbull (1982) discussed three problems parents encountered in IEP development: (a) parents are viewed as a homogeneous group, (b) each parent is involved in programming in the same way and to the same extent, and (c) parents do not decide their level of involvement. Although parents have the right to review and approve the IEP (Mallory, 1981), schools have not been encouraged to address families’ needs (Bailey, 1989). Because the IEP does not lend itself to including family goals (McGonigal & Garland, 1988), the inclusion of the family in the IFSP process marks a significant departure from existing policies. Inclusion of the family in the IFSP process implies recognition of the important role that the family has on the child’s life (Krauss, 1990).

The IFSP must include a statement of the family’s strengths and needs related to enhancement of the child’s development (Public Law 99–457, § 303.322 b). The family unit, rather than the special needs of the infant or toddler, is now recognized as the appropriate focus of services (Bailey, 1989; Bailey et al., 1986; Krauss, 1990). This approach is the hallmark of family-centered care (Hanft, 1988), which ensures quality practice for infants, toddlers, and their families (Krauss, 1990).

No other area of the IFSP has generated greater controversy than the inclusion of the family (McGonigal & Garland, 1988). The premise of this approach is that every family can support the development of their child with special needs if they have the right resources (Smith, 1988). A determination of the family’s resources, needs, and coping strategies is important for the identification of strengths and needs (Zeitlin & Williamson, 1988). Assessment of family resources, needs, and coping strategies has presented a special challenge (McGonigal & Garland, 1988).

Assessments must be flexible so as to reflect the diversity of families (McGonigal & Garland, 1988). However, the law does not state which domains of family life should be assessed, how to assess them (Bailey et al., 1989; Krauss, 1990; Summers et al., 1990), or which family members need to be assessed (Smith, 1988). Bailey et al. (1986) suggested three areas of family assessment: (a)
child variables, such as behavior and temperament, as related to family function; (b) the family's need for support, information, and training; and (c) parent-child interaction. Issues of family privacy surface quickly as service providers debate how in-depth family assessment should be (Krauss, 1990).

Once the assessment is completed, the family's strengths and needs related to enhancing the development of their child must be identified. If the IFSP is to accurately reflect the family's outcomes, the family members must identify their own needs and priorities (Bailey et al., 1986; McGonigel & Garland, 1988; Smith, 1988). Outcomes should not be written for family compliance with program priorities and procedures (McGonigel & Garland, 1988). The professional must remember that the outcomes should reflect the family's priorities and values rather than his or her own. Controversy may develop when the family's and the professional's perceptions of needs differ (Krauss, 1990; McGonigel & Garland, 1988). The challenge is to develop a collaborative relationship between the professional and the family so that information, skills, and recommendations are shared to support rather than supplant the family (Bailey, 1987; Freeman, 1989; Krauss, 1990; McGonigel & Garland, 1988).

Families prefer informal methods for identifying their strengths and needs (Summers et al., 1990). Identified outcome areas should be flexible and should involve suggestions rather than definite goals (Abel-Boone, Sandler, Loughry, & Frederick, 1990). According to Summers et al. (1990) and Ziegler (1989), typical families need information about the disability; relevant laws; available services; state-of-the-art education programming; financial assistance and location of community resources; effective, assertive communication methods; documentation methods; and advocacy strategies. Families also need access to strategies and techniques for interacting and working with their child.

Outcomes for the Child and Family

This component is conceptually similar for both the IEP and the IFSP. In the IEP, annual goals, including short-term instructional objectives, are mandated. In the IFSP, major outcomes expected to be achieved for the child and family are mandated. This must include the criteria, procedures, and time lines used to determine the degree to which progress toward achieving the outcomes is being made. Provisions must also be made for modification or revision of the outcomes or services, as needed (Public Law 99-457, §303.344 c). General considerations for the establishment of outcomes are (a) use of a variety of outcome measures (Guralnick, 1981), (b) preparation for future integrated settings, (c) emphasis on skills with both present and future use, and (d) conduct of transition planning (McDonnell & Hardman, 1988).

Two differences are apparent between the IEP and the IFSP. First is the consideration as to which family outcomes must be monitored (Krauss, 1990). Other questions involving the family are, (a) Should the family's goals be separate from the child's and family's goals? (b) Will exact strategies need to be identified? and (c) Do outcomes need to be written to accommodate a change in service providers without changing the entire IFSP? (Smith, 1988).

The second difference is that "the IFSP appears to lack the contractual basis of the IEP, potentially leaving it to be viewed as a 'wish list' of recommendations" (Dokecki & Hellinger, 1989, p. 71). In the IFSP, outcomes may be identified that are not within the realm of the lead agency. Provision of and payment for these services are not necessarily a part of Public Law 99-457 (see the Other Services section). In contrast, the IEP is a contract for services that must be provided by and paid for by the lead agency.

Intervention Services

This component is similar in the IEP and the IFSP. Specific special education and related services to be provided to the child and the extent to which the child will be able to participate in regular education programs are included in the IEP. A statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes, including the frequency, intensity, location, method of service provision, and payment arrangements, if any, are included in the IFSP (Public Law 99-457, §303.344 d).

Two differences are apparent between the IEP and the IFSP. The first difference is that the IEP includes the extent to which the child will be mainstreamed, which has not been an issue with infants and toddlers at this time. However, an appropriate issue for infants and toddlers is the location of service provision (Smith, 1988). Families of infants and toddlers have more options available to them. Families need to be educated about the advantages and disadvantages of center-based, hospital-based, and home-based services so that they can select the one that best meets their needs. Collaboration among the medical, educational, and social service providers is important as these options are explored (Smith, 1988). The second difference is in the inclusion of payment arrangements as appropriate on the IFSP. Because the lead agency provides services free of charge for the IEP, this is not necessary on the IEP.

Other Services

The inclusion of other services is unique to the IFSP. Part H of Public Law 102-119 recognizes that many medical services are necessary in order for the infant or toddler to benefit from an education. Therefore, to the extent appropriate, the IFSP must include medical and other serv-
services that the child needs but that are not required and, if necessary, the steps that will be taken to secure those services through public or private resources (Public Law 99-457, § 303.344 e). For example, if the child must be followed by a pulmonologist due to chronic respiratory problems, this information should be on the IFSP.

Dates and Duration of Services

Both the IEP and the IFSP must include the projected dates for initiation of services and the anticipated duration of those services.

Objective Criteria and Evaluation Procedures

Both the IEP and the IFSP must include appropriate objective criteria in evaluating program effectiveness. This must be done at least yearly with the IEP and on a semiannual basis with the IFSP.

Selection of a Case Manager

The involvement of a case manager is unique to the IFSP. The IFSP must include the name of the case manager from the profession most immediately relevant to the child’s or family’s needs who will be responsible for the implementation of the IFSP and for coordination with other agencies and persons. In meeting these requirements, the public agency may do one of two things: It may assign the same case manager to be responsible for implementing a child’s and family’s IFSP who was appointed at the time that the child was initially referred for evaluation or it may appoint a new case manager (Public Law 99-457, §303.344 g).

Case management is defined as the activities carried out by a case manager to assist and enable a child and his or her family to receive the rights, procedural safeguards, and services that are authorized to be provided under the state’s early intervention program. The case manager (a) coordinates the performance of evaluations and assessments; (b) facilitates and participates in the development, review, and evaluation of IFSPs; (c) assists families in identifying available service providers; (d) coordinates and monitors the provision of available services; (e) informs families of the availability of advocacy services; (f) coordinates with medical and health providers; and (g) facilitates the development of a transition plan to preschool services, if the services are appropriate (Public Law 99-457, §303.6 a & b).

Prior to the regulations for Public Law 99-457, the Division of Early Childhood (1987) recommended that the professional and the parent serve together as case managers. However, in interpreting the law, the secretary of education has indicated that families should not be named as case managers, because Congress did not intend for the parents to assume that responsibility (U.S. Department of Education, 1989). Therefore, the Division of Early Childhood (1987) recommended that the case manager be chosen from the agency with the greatest portion of services in the IFSP or that he or she be currently employed directly by the interagency coordinating council. The choice of the individual professional chosen as case manager should be up to the family (Division of Early Childhood, 1987).

The selection of the case manager’s approach depends largely on the manager’s training. Dunst and Trivette (1986) discussed three approaches to case management: (a) the procurement approach, in which the family passively receives services; (b) the mobilization of support systems to meet needs, in which the family plays a more active role; and (c) the client empowerment approach, in which the family is actively involved in decision making. Each approach has positive and negative influences on the family (see Dunst & Trivette 1986 for an elaboration of these influences).

Questions yet to be answered in case management include, (a) Do state licensing laws dictate who can be the case manager? (b) When and in what process is the case manager identified? and (c) Can the case manager be changed? (Smith, 1988). Should case managers be responsible to implement the IFSP or should the family be responsible? If the former, the family may likely become a passive rather than an active recipient of case management services (Dunst & Trivette, 1986).

Transition Plans

The IFSP must include the steps to be taken to support the transition to preschool services for the child who has reached 3 years of age, to the extent that those services are considered appropriate or to the extent that other services may be available if appropriate. The steps required to support transition are (a) discussions with, and training of, parents regarding future school placements and other matters related to the child’s transition; (b) procedures to prepare the child for changes in service provision, including steps to help the child adjust to and function in a new setting; and (c) with parental consent, the transmission of information about the child to the local educational agency so as to ensure continuity of services, including evaluation and assessment information, and copies of IFSPs that have been developed (Public Law 99-457, §303.344 h).

The transition plan is a unique component of Public Law 99-457, although a transition plan is required on the IEP for those children older than age 16 years. The difference is that the case manager is ultimately responsible for the implementation of the plan and the family role in transition must be stated on the IEP (Noonan & Kilgo, 1987). Successful transition plans allow the therapist to prepare the child and family for the move; support the child and family as the plan is implemented; and follow up.
with the child, family, and new service provider once the transition is complete (Noonan & Kilgo, 1987). Specific requirements are included in the law, but the professional must remember that the family retains the ultimate approval for the transition plan (Public Law 99–457, §303.344 h).

Summary

In this paper, I have provided a summary of the similarities and differences between the IEP and IFSP. Four principles guide the IFSP process: (a) families and professionals must collaborate, (b) the family must authorize services, (c) professionals must respond to the broad-based needs of the family, and (d) competencies of the family should be promoted (Deal et al., 1989). Flexibility is a key to responding to the changing needs of families in the IFSP process (Abel-Boone et al., 1990; Deal et al., 1989). Occupational therapists must be aware of these principles and must be ready to respond to challenges in the development of individualized programming.

In response to the demands of the IFSP, new responsibilities exist for professionals currently working in early intervention and for those in training programs. It is necessary that we have interdisciplinary training programs that include knowledge of the wide range of family services, structural and programmatic changes in the design of early intervention services, expansion of services to families from traditional early intervention boundaries, and development of referral mechanisms available in the community and state (Krauss, 1990).

The IFSP may be viewed as a radical or a fundamental change (Krauss, 1990). If the change is viewed as radical, there will be resistance from professionals. If the change is viewed as fundamental, implementation of the IFSP regulations will focus on best practices that result in full compliance. Because professional and parental boundaries are redrawn in Part H of Public Law 99–457 and reconfirmed in Public Law 102–119, a new service framework must be established. This new framework challenges current practices in many early intervention programs. This challenge extends to collaboration between families and service providers as well as to education, health, and social service agencies (Hanft, 1988; Krauss, 1990). Occupational therapists providing services to infants and toddlers must educate themselves by reading or attending inservices about the challenges of the IFSP. In addition, preservice programs must include the unique provisions of the IFSP process in their classrooms.

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References


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