EBP Edge—Serving Children Living in Poverty: Implications for SLP Service Delivery

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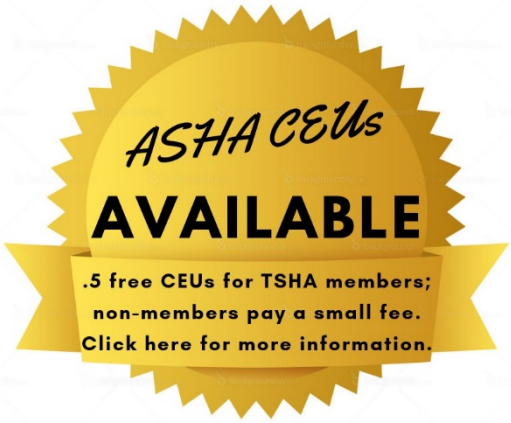
As speech-language pathologists (SLPs) serving a variety of individuals across many settings, it is important to understand the impact of poverty on our caseloads and use evidence-based strategies to better support low-income families. The American Speech-Language-Hearing Association (ASHA) outlines eight domains of service delivery: collaboration, counseling, prevention and wellness, screening, assessment, treatment, modalities, as well as technology and instrumentation. The needs of children and families living in poverty exist across all of these domains and therefore should be an essential consideration for the plan of care.



When SLPs empower patients with independence and strategies to meet their goals, these individuals may be better equipped to participate fully in their daily livesthrough more successful communication. However, families living in poverty do not always have adequate resources or access to advocacy to meet all the needs of family members. As the effects of poverty are not limited to the home, SLPs in all settings have an obligation to partner with these patients and families to bridge the gap by being a partner in advocacy for the family unit and their client.

It is extremely important to note that poverty alone does not result in impairment or inadequacy. Although there is valuable research regarding families living in poverty, careful consideration must be given to any inherent bias present. When interpreting research related to poverty, the reader can identify racial and cultural prejudice in terms of privilege and equality; research studies do not always include experiments involving adequate racial and cultural representation or diversity. Additionally, researchers and SLPs should have knowledge related to the culture of the family and be prudent not to pathologize language differences. Acute awareness of the inequalities present in access to healthcare, education, and resources also should be acknowledged when planning with the family.

Poverty in Texas

To best serve families living in poverty, SLPs may find it helpful to consider and identify the different ways a family may be disadvantaged. “Income poverty,” or lacking sufficient income to meet the federally established threshold, was originally developed in the 1960s by the Social Security Administration. This threshold was based on the assumption that the average cost of food needed during one week for a family accounted for about one-third of the household total income (U.S. Department of Health & Human Services, 2017). Presently, the Census Bureau calculates the poverty threshold by using “a set of money income thresholds that vary by family size and composition;” therefore, if a family’s total income is less than the threshold, the family is considered to be living in poverty (U.S. Department of Health & Human Services, 2017).

Although poverty thresholds are updated annually for inflation using the Consumer Price Index, it does not consider other expenses a family may have, such as education, transportation, or medical costs (U.S. Department of Health & Human Services, 2017). Additionally, the number of people living in suburban areas has significantly increased, but the standard of poverty has not been adjusted to account for urban versus rural areas across the country. Programs such as Medicaid, Children’s Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP),

and Women, Infants, and Children (WIC) also use these federal guidelines to determine eligibility (U.S. Department of Health & Human Services, 2017).

Pierre Sané, a former UNESCO Assistant Director, offered an expanded view of poverty, which may also be helpful for SLPs to consider:

1. Economic Poverty – Inability to work and have adequate income
2. Social Poverty – Limited access to healthcare, education, nutritious foods, healthy relationships, etc.
3. Political Poverty – Decreased access to freedom of thought, expression, and association to your own beliefs
4. Cultural Poverty – Lacking the right to maintain a person's cultural identity and be involved in their community

The overall poverty rate in Texas was 14.7% in 2017, making it the 14th highest state for poverty across the United States (TalkPoverty.org, 2018). In 2017, one in five children under 18 years of age lived in poverty in Texas, and poverty rates were highest for African American and Latino populations (Tingle, Zhang, & Deviney, 2018). It's also worth noting that 32.8% of children in Houston, 30.6% of children in Dallas, and 26.2% of children in San Antonio are living in poverty, ranking those three cities in the top 10 among large cities across the United States (U.S. Census Bureau, 2016).

In Texas, there was an average of four children living in foster care for every 1,000 children under the age of 18 in 2016 (TalkPoverty.org, 2018). Households with food insecurities were at 14% on average from 2015-2017, meaning that at some point during the year they experienced difficulty providing enough food due to a lack of money or resources ("Poverty Data State by State," 2018).

Texas has the highest percentage (31.7%) of people under age 65 who did not have health insurance at any time in 2017 ("Poverty Data State by State," 2018). Although it is important to note, despite the unemployment rate being 4.3% in 2017, more than half of the families who met the federal poverty threshold in Texas were considered "working families" (TalkPoverty.org, 2018).

Effects of Poverty on Children

The effects of poverty can be seen across all stages of a child's development. Many refer to poverty as a cycle of lacking access to healthcare and resources that can continue across generations. Research suggests children living in poverty are at greater risk for disabilities than those living in middle-class or higher-income households ("Speech and Language Disorders in Children," 2016). Additionally, research indicates that poverty in childhood can exacerbate disabilities and their effects(Chokshi & Khullar, 2018). This can yield differences in emotional, social, and mental development; academic achievement; and employment opportunities during adulthood (Fujiura and Yamaki, 2000; Kuhlthau and Perrin, 2001; Kuhlthau et al 2005). Children with disabilities may have increased vulnerabilities, more need for healthcare, and overall poorer health (Kuhlthau et al 2005).

Physical Effects

Studies show children living in poverty may have worse health overall compared to peers living above the poverty threshold, perhaps due to limited access to healthcare or environmental factors present at home (Brooks-Gunn & Duncan, 1997). Additionally, a study by Porterfield and McBride indicated parents with lower income and less education were less likely to report that their special needs children required specialized health services when compared to higher-income families (2007). Pregnancy for mothers with limited access to prenatal care may result in low birthweight, prematurity, or increased stress before or during labor. As children living in poverty develop, they can be at a higher risk of chronic illness, undiagnosed medical and hearing/vision problems, or malnutrition and food insecurity (Brooks-Gunn & Duncan, 1997). Children with inconsistent housing or unsafe housing conditions may miss more school than their peers, could be more often fatigued, and may be exposed to more harmful toxins such as lead (Brooks-Gunn & Duncan, 1997).

Psychological Effects

Living in poverty can create higher familial stress, increase the risk of depression and mental health issues at home, and decrease a caregiver's capability to respond. This, in turn, may decrease a child's opportunity for a language-enriched environment. Research shows living in poverty and being exposed to adverse situations can lead to significant impacts on a child's learning, behavior, and overall health (Committee on Psychosocial Aspects of Child and Family Health et al., 2012).

Educational and Employment Effects

Research indicates children from low-income homes may develop academic skills more slowly than children from higher-income groups due to opportunities for exposure and supported practice. Living in poverty during childhood also has been linked to poorer cognitive development, language and memory skills, emotional intelligence, and consequently poor income and health in adulthood (Morgan et al., 2009). In 2009, high school students living in poverty were five times more likely than high-income students to drop out, possibly limiting opportunities for employment as adults (Chapman, Laird, Ifill, & Kewal-Ramani, 2011, Table 1).

Language and Literacy Effects/Feeding Development Effects

It is especially important for clinicians to understand the effects of poverty on expressive and receptive language learning, pre-literacy and literacy skills, and overall ability to communicate effectively. If the SLP treats feeding disorders or dysphagia, it is also imperative to be sensitive to the effects of poverty in this population as well. The bulleted list below highlights a summary of current research regarding the skills and development of children living in poverty in comparison to peers living in higher-income households.

Language Development

Children from low-income families may have more limited input, in terms of quantity and quality, when compared to children from wealthier families, and these differences have been linked to delayed language abilities (Pruitt & Oetting, 2009).

- Poverty may be associated with deficits in language learning, executive functioning, and memory due to high stress levels found in low socioeconomic-status (SES) children (Farah, Shera, Savage, et al., 2006; Nobel, Norman, Farah, 2005).
- Conversations in low-income homes may often include only the most commonly occurring words (i.e., extremely limited abstract, decontextualized language used) (Weizman & Snow, 2001).

Literacy Skill Development

- Children's early reading skills could correlate with the home literacy environment, number of books owned, and parental distress present in the home (Aikens & Barbarin, 2008; Bergen, Zuijen, Bishop, & Jong, 2016).
- Children living in poverty who were successful readers may have been exposed to rich vocabulary, extended discourse, cognitively and linguistically stimulating home and school environments, as well as early experiences that encouraged phonological awareness (Dickinson & Tabors, 1991; Buckingham, Wheldall, & Beaman-Wheldall, 2013).
- Children from low-income homes possibly began high school with average literacy skills five years behind those of high-income students (Reardon, Valentino, Kalogrides, Shores, & Greenberg, 2013).
- Low-income communities may average about one book for every 300 children, whereas a middle-class neighborhood may average 13 books per child (Moran, 2010).

Feeding Development

- Children living in poverty may be exposed to increased stress, anxiety, and food insecurity at home, which can shape a child's early experiences with food (Tartakovsky, 2012).
- Mothers living in poverty could have increased risk of preterm birth as compared to others with higher incomes (DeFanco et al, 2008). Preterm birth is significantly associated with dysphagia (Jadcherla, 2016).
- Children with language impairments may be three times more likely to have earlier feeding and swallowing difficulties than the general population (Malas et al, 2017).

Early Intervention for Children in Poverty

The importance of early intervention (EI) for children with disabilities and their families has been well established by research. High-quality EI services can change a child's developmental path, improve outcomes for children and their families, and is likely to be more effective and less costly when provided earlier rather than later (Center on the Developing Child at Harvard University, 2010).

Positive experiences with early social and emotional interactions, as well as good physical health, can establish the foundation upon which cognitive and language skills develop. The Center on the Developing Child at Harvard University summarized research stating "persistent 'toxic' stress such as extreme poverty, abuse, and neglect or severe maternal depression can damage the developing brain, leading to lifelong problems in learning, behavior, and physical and mental health" (2010).

Despite the known benefits of EI, only 2.67% of the general population of children aged birth to three received early intervention (Data Accountability Center, 2010). However, research indicates that as many as 13% have delays that would make them eligible under the criteria states commonly use (Rosenberg, Zhang & Robinson, 2008). Additionally, African American children who would be eligible for EI services at 24 months of age may be up to five times less likely to receive services than white children (Feinberg, Silverstein, Donahue & Bliss, 2011). A child's brain is likely influenced by positive early experiences, stable and positive relationships, adequate nutrition, and safe and supportive environments. Children living in poverty may not have equal opportunities to access these areas as do those with higher incomes. SLPs can provide services that increase a child's ability to develop skills that will provide lifelong achievement.

Considerations for Sensitive Therapy Practices

When serving individuals living in poverty, it is essential to reflect on the entire relationship of poverty and the potential cycle on developing children. This includes considerations of privilege, racism, and classism and how these influences affect our approach to therapy. Classism, or the systematic assignment of characteristics of worth and ability based on social class, includes individual attitudes, policies and practices resulting in wealth inequality, and the oppression of subordinated class groups to advantage and strengthen the dominant groups (*Classism.org).*SLPs can practice mindfulness and self-awareness when partnering with families living in poverty to avoid a negative cultural footprint or power discrepancy. In addition, SLPs can help families advocate for needed services.

Cultural Footprint

Scientists now describe the "cultural footprint" as a way of measuring the pressure exercised by human action on the biosphere. As SLPs, our cultural footprint involves our own culture, background, ethnic group, community, religious beliefs, and societal opinions. When we carry these experiences with us into our care of patients, we begin to leave our mark on others and change that biosphere. We may inherently possess the power of privilege just by being viewed as the "expert" joining the care team. When we are mindful of the potential imbalance between the SLP and the family, we can utilize sustainable approaches to therapy that empower and do not create dependencyon the SLP or services provided.

Sustainability is the ability to be maintained at a certain level or across time. The United Nations Brundtland Commission defined it in 1987 as "meeting the needs of the present without compromising the ability of future generations to meet their own needs" (Academic Impact, UN). In regards to speech therapy services, sustainable approaches establish the caregiver as the expert on

the child, and it is the SLP's responsibility to learn from the family before making changes. Incorporating new skills should complement what is already in place in the child's life. Research indicates caregivers may perceive advantages of "partnership programs" rather than "rigidly prescribed" programs (Novak, 2011). It could be concluded that sustainable approaches in speech therapy services empower families to sustain independence outside of therapy.

Another interesting perspective to consider is equality versus equity. Equality is defined as treating everyone the same, whereas equity is ensuring all individuals have what they need to be successful. Although equality targets fairness, it is only successful if everyone has the same opportunities and access to the necessary resources and help available. This is an important concept to understand when serving families and individuals from different backgrounds than our own.

Compliance Becomes Collaboration

Compliance refers to the act of cooperating with another's wish or command. There are many reasons why a patient or family could be considered "noncompliant," such as missing multiple appointments or not implementing diet changes. However, the perspective of compliance could assume the SLP is enforcing their request upon the family without consideration of their order of concernsor needs.

The Hierarchy of Needs theory was first introduced by Abraham Maslow in 1943 and is often represented by a hierarchical pyramid with five levels (Maslow, 1943). The four lower levels are considered physiological needs, while the top level is reserved for growth needs (Maslow, 1943). The lowest level involves physiological needs (e.g., air, food, water, sleep) before then moving up to safety needs (e.g., environment, employment, resources, health, property). Further up is belongingness (e.g., love, friendship, family) and self-esteem (e.g., confidence, achievement, respect). The highest level is self-actualization, which includes morality, creativity, problem-solving, etc. It was Maslow's theory that the lower-level needs must be satisfied before higher needs could influence behavior (David, 2014).

It may be beneficial for SLPs to consider the Hierarchy of Needs theory when working with families and patients and setting expectations for participation in therapy. A practical example may be serving a patient living in a "food desert," where access to adequate nutrition options may be limited due to both transportation and the financial resources of the family group. This patient/family may be struggling to meet all needs at the "physiological" level and therefore may be less likely to be confident in problem-solving when collaborating with the SLP on planning to incorporate new textures or food groups with the dysphagia/feeding patient. It may not be within the scope of the SLP to address certain needs related to their well-being, such as a sibling's self-harming behaviors or maternal depression; however, SLPs could refer to other healthcare professionals and serve as a resource to families about available services in the community.

When one feels vulnerable, unprepared, or inadequate, there may be a natural tendency to withdraw. SLPs can change their view of compliance to a more collaborative approach, taking more responsibility for ensuring the family is prepared to actively participate and partner together in therapy. The SLP may invite caregivers to discuss what works well for their family, what isn't working, and what level of involvement the caregiver is realistically able to commit. Additionally, the SLP could initiate discussions about the care plan and help make changes to increase their investment and contribution and ultimately their ability to advocate for themselves.

Implications for Service Delivery

SLPs have the responsibility to support all families and patients, regardless of income, by providing sensitive, high-quality support in our plan of care. However, when serving families living in poverty, it is particularly important to consider two principles—caregiver coaching and protective factors approach. The goals of sensitive service delivery areto: (1) increase patient independence and safety in all environments; (2) empower families to use evidence-based strategies at home and advocate for needed services; (3) offer opportunities to practice skills in natural environments; and

(4) partner with the family at an appropriate time with the most appropriate care. Strategies to achieve these goals are described below.

Caregiver Coaching

Family-Centered Care
The family-centered plan of care determines the family's priorities through partnership, education, and empathetic listening. Therapy can be very effective and sustainable when the family expresses their main concerns, feels validated and valued, and invited to problem-solve together as a team. SLPs can develop the trusting partnership among caregivers, family members, and the patient in order to foster this collaboration.

The quality of interactions between healthcare professionals and families living in poverty may be more complex than patients from higher-income homes. Research suggests patients living in poverty may be more likely to have shorter consultation times than higher-income patients (Stirling, Wilson, & McConnachie, 2001) and may be less likely to be involved in their treatment decisions (Willems et al, 2005). Additionally, patients from low-income homes may be less willing to share social problems due to concerns of stigma and/or discrimination (Barry et al., 2000).

As professionals viewed as experts, clinicians can be sensitive to the potential inequality naturally present when speaking with families. Awareness of the family's immediate needs and their ability to respond to recommendations is essential in the plan of care. Using common vocabulary terms and statements with unambiguous information allows the family to engage in conversation instead of being passive listeners. This plan ensures caregivers and patients have an opportunity to ask questions and assume responsibility for their role in the plan of care.

"For patients and families, the evaluation, consultation, and every particular therapy session have the potential to hold lasting meaning that is profoundly important. For lasting meaning to occur and change in the course of a life, a therapist must be committed to behaviors that create interactional relationships" (Burke, 2010).

Caregiver Empowerment
SLPs can provide referrals to community-based resources when appropriate, such as locally and federally funded programs, food pantries, public libraries, social workers, or support groups. However, it is not enough to only recommend and refer; SLPs also must use empathetic listening and continuously connect with the family to ensure their basic needs are met in order to best support the patient.

SLPs can empower caregivers to use strategies confidently and independently in existing life routines, creating more sustainable outcomesfor all families, regardless of income. Research indicates strategies that involve caregivers can be successful, which may be particularly relevant to families living in poverty. One study showed parents reported increased participation and carryover of strategies when recommendations were "easily incorporated into the daily routine" and when the therapist confirmed strategies were being used correctly (Lillo-Navarro et al, 2015). Modeling how to include therapy goals during transitions, chores, and daily life activities increases a caregiver's ability to carry over progress. Clinicians can increase the chances for success by inquiring about the family's activities and then tailoring recommendations or strategies to fit into their routine. When SLPs use these strategies, the potential footprint left on the family by the SLP (i.e., influences of culture, background, ethnic group, community, religion, opinions, affect, etc.) is decreased.

Roberts and Kaiser (2011) noted parents may be as effective as therapists when they receive appropriate guidance and teaching from the SLP. To do this, SLPs should use active teaching methods, feedback, and continuous reassessment to determine progress and most effective strategies. This allows the family to remain involved in the plan of care and maintain positive communication between the therapist and the caregivers.

Barriers to Participation in Therapy

Barriers to caregiver or patient involvement may include limited access to health care, food insecurity, uncertain or unsafe housing conditions, inconsistent access to transportation, family stress, mental health issues/depression, low health literacy, or feelings of shame or inadequacy. One study noted that “providing a mother with information about normal child development or about how to stimulate the child may be of little use unless the mother’s own life circumstances are addressed first” (Bee et al., 1982), further supporting Maslow’s Hierarchy of Needs theory. These are important to remember when the SLP provides education and strategies and has expectations for participation in therapy. The SLP could provide referrals to other community-based resources when appropriate to support the caregiver’s needs.

Caregivers with unaddressed life stressors may not be as able to foster a linguistically-enriched environment at home, participate in creating goals, or use problem-solving strategies if they do not feel confident, safe, and healthy. One study showed the extent to which mothers respond to their 13-month-old children may predict the timing of children’s development of their first 50 words and use of two-word utterances (Tamis-LeMonda, Bornstein, & Baumwell, 2001). Additionally, Novak (2011) reported too much pressure to participate in therapy without support resulted in negative feelings and the increased likelihood of the parent discontinuing work with the therapist. Therapy is not likely to be therapeutic if the patient and caregivers are unable to carryover strategies to their natural environment and feel supported in the plan of care.

One other important consideration to caregiver participation involves health literacy. Health literacy is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Ratzan & Parker, 2000). Low health literacy can span across all racial and ethnic groups but is generally associated with less education (U.S. Department of Health & Human Services, 2008). Red flags for low health literacy may include: delayed follow-up or frequent missed appointments, resistance to referrals, lack of questions and knowledge of case history, unfamiliar or limited understanding of commonly used medical terms, and anger, passiveness, or humor used to deflect from issues.

Strategies to increase health literacy include using simple language and shortened statements, delivered in chunks to increase understanding and retention. When checking for understanding, the SLP should assume responsibility for clear explanations and ensure the caregiver is able to repeat the plan back using their own words. Printed materials should be written with technical terms defined and reviewed or explained verbally. Underlining or highlighting the important information also may be helpful. In cases in which families have limited English proficiency and written information cannot be shared in their native language, a translator or interpreter should be utilized.

Protective Factors Approach

As SLPs are often a member of a multidisciplinary team, we collaborate with other professionals to reduce risk factors and effects of medical disorders and conditions. However, another important consideration for SLPs includes using a protective factors approach, which may be even more significant when serving families living in poverty. Protective factors are “conditions or attributes of individuals, families, communities, or the larger society that mitigate risk and promote healthy development and well-being” (childwelfare.gov). This can allow the SLP to engage families by focusing on their strengths and also building a strong foundation for a mutual partnership. Using a protective factors approach may include supporting caregiver resilience, social connections, knowledge of parenting and child development, specific supports in times of need, and social-emotional competence in families (childwelfare.gov).

Although the protective factors approach has not been well-documented in the SLP literature yet, it could be extremely relevant to our field and applied to families living in poverty in particular. Research indicates socioeconomic status can affect family stability and developmental outcomes for children (Trickett, Aber, Carlson, & Cicchetti, 1991). Poverty may be a reliable predictor of child abuse and neglect and linked to higher psychological stress and poor health outcomes (Ondersma,

2002; Melki et al., 2004). Additionally, maintaining a strong parent-child bond may promote healthy child development, particularly for children living in poverty (Milteer, Ginsburg, & Mulligan, 2012). It could be concluded that the family well-being is an important aspect of supporting families living in poverty when providing SLP services.

One study identified that using a protective factors approach can support the following skills for "at-risk" children: self-regulation, relational/social skills, problem-solving, parenting competencies, and academic achievement (*Literature Review: Executive Summary, 2013*). The protective factors approach highlights the importance of quality relationships and promotes intervention that invests in caregivers' skills, capacity, and ability to nurture as important in positive child outcomes (childwelfare.gov).

SLPs working with patients and families in all settings may find it beneficial to consider the degree of stability in a child's social, emotional, and physical environment and the extent to which a caregiver is available and able to sensitively and consistently respond to and meet the needs of the child. SLPs working with caregivers can model positive interactions, language enrichment, and promote healthy social-emotional bonds that allow for language development. In these ways, SLPs can provide family-centered care that empowers caregivers, recognizes readiness for intervention, and supports families in the home.

Working with Patients to Provide Sensitive, High-Quality Care

Naturalistic Environment

SLPs can model and teach new skills using strategies that allow for independent or supported practice with later feedback in the natural environment. Research supports that opportunities to practice skills in a patient's daily life may be just as important as the quantity of hands-on therapy received (Novak, 2012). The SLP can determine functional and family-identified goals and implement goals through developmentally appropriate play and practice. In order to increase patient independence, the natural environment should be safe, allow for visual and physical exploration, have predictable routines, and have opportunities for joint attention and joint play. SLPs may need to provide caregiver coaching and modeling to implement and promote language enrichment at home.

Assessment Considerations

Language and culture are indissoluble, being so intertwined together it is difficult to discuss one without the other. Therefore, when assessing a child's language and communication skills, it is imperative to consider the cultural influence as well.

It is important for SLPs to acknowledge the bias present in gathering and analyzing information as well as our own personal perceptions. However, it is possible to complete a valid and culturally competent assessment, even if the SLP does not share the same cultural background or native language. Format bias, or a procedure that does not match the child's cognitive style, may result in decreased ability on unfamiliar tasks (Goldstein, 2000). Comparing a child's language skills to a normative sample that is not the same would not accurately represent the child's language development and result in linguistic bias. Additionally, when communication expectations are blanketed across cultures, a child may be identified as disordered when in fact their skills are typical for their background. SLPs can increase self-awareness and obtain additional resources regarding minimizing examiner bias by using the Cultural Competence Checklist developed by ASHA and available online.

Careful consideration must be given to the limitations of standardized assessment tools as well as inherent bias present when determining a difference versus a disorder. As payer sources continue to rely on standardized assessments to determine qualification for therapy, SLPs must be diligent in proving medical necessity by providing a representational view of the whole child through the description of language skills and acknowledgement of bias present. An assessment test may not reveal a child's opportunity for practice and exposure to new concepts or their ability to learn and apply information in a variety of environments.

SLPs should use dynamic assessment to identify deficits and to differentiate between a language difference due to bilingualism or a culturally and linguistically diverse background, lack of exposure to high-quality language models, or a true language disorder (Dynamic Assessment, 2012). Dynamic assessment shows that if a child is able to retain information after being exposed to active learning strategies and explicit instruction, the child does not demonstrate a true language disorder. In addition to dynamic assessment, the SLP can use an ethnographic interview to obtain case history and learn about the patient's culture, background, and perspectives. Formal observation, play-based assessments, and spontaneous language samples are also helpful to include. Of course, a child exposed to more than one language must be assessed for language proficiency in each language in order to determine how to most appropriately assess the child. Using these strategies can help guide the SLP in their clinical decision-making as they recommend patients for therapy or to educate caregivers.

Executive Functioning and Emotional Intelligence

Using and teaching strategies that increase executive functioning skills and emotional intelligence can increase academic success and language skills for children living in poverty. Research suggests verbal ability and knowledge of emotions in children may be predictors of academic success in first grade (Trentacosta & Izard, 2007). One study showed childhood poverty can actually reshape the brain mechanisms that regulate emotions even as an adult (Liberzon et. al, 2015). Emotional intelligence is correlated with more positive relationships, healthier habits, and higher quality of life as an adult (Cherniss & Goleman, 2001). However, opportunities for practice in positive environments are imperative to developing these skills.

Including patients in their own plan of care can promote problem-solving skills and support their ability to plan and prioritize their goals. Throughout therapy, SLPs can target attention and self-regulation, which are important skills that contribute to executive functioning. Inviting patients to label and discuss their emotions as they participate in therapy increases self-expression, builds empathy, and decreases communicative frustration. Using strategies that target and increase executive functioning and building emotional vocabulary and problem-solving skills will prepare children for future success.

Patient Empowerment

Episodic care is functional therapy with a defined beginning and end that allows for a supported transition to the community that empowers patients to apply skills learned in therapy to their daily routines and environments. Once the patient has had opportunity to trial strategies away from therapy, they are able to return to therapy to obtain needed new skills or to refine skills with feedback from the real-world trials. Research supports that structural changes must complement functional changes for sustainability (Dobkin, 2005). This provides SLPs with considerations for treatment frequency/dosage, duration, and thresholds for therapy in the plan of care. We are obligated to provide the right amount of care at the right time. This suggests a patient or family may not be ready or able to participate in the most intensive initial approach to therapy due to unaddressed life stressors, imbalances on the family's hierarchy of needs, or perhaps a delay in acceptance of the need for therapy. Despite the SLP recommendation for services twice a week, perhaps the family is only able to commit to one time a week due to scheduling conflicts. Through collaboration with the family, the SLP can ensure the recommendations made for the therapy plan of care consider all the needs of the family and ultimately support achieving the goals formulated.

SLPs can invite patients of all ages and abilities to share in the therapy plan by offering choices, discussing priorities and goals, and clearly stating expectations. By encouraging patients to problem-solve as a team and incorporate their own daily routines into therapy, we respect their autonomy and create a therapy plan that can be realistically achieved. SLPs can empower patients by using memory aids, modeling easily implemented strategies, and teaching tools to self-advocate by being prepared to educate the family about resources of support available in the community.

"People are happier, more cooperative and productive, and more likely to make positive changes when those in positions of authority do things WITH them rather than TO them or FOR them" (Smull, Wachtel, Wachtel, 2012).

Conclusion

Research highlights the critical role of SLPs in supporting children and families living in poverty. In order to achieve evidence-based practice in our therapy plan, SLPs must consider the whole child as part of a larger family unit and partner with families to actively share the responsibility of care. Awareness of our own bias and acknowledgement of any potential equality imbalance present when we are viewed as the expert can increase our ability to serve and embrace others. Increasing access to resources and empowering patients and families with tools to increase independence and participation are within the SLP scope of practice and are crucial for best practice service delivery.

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