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ABSTRACT
        This collection of materials was gathered as part of
a project to develop and implement a faculty training institute for
early intervention personnel in 12 states in the Northeast. The
project's emphasis was to train interdisciplinary faculty to infuse
basic early intervention content into existing course work, develop
new course work or modify existing course work to include early
intervention issues, and provide periodic inservice training.
Introductory material describes the NorthEast Early Intervention
Faculty Training Institute project, discusses the project's
importance, and reports on its impact. Among the types of materials
included in this collection are outlines, annotated bibliographies,
materials for handouts or transparencies, lists of course objectives,
essays providing background information, lesson plans, suggestions
for learning activities, case studies, and resource lists. Set 1,
titled "Services for Families," contains two modules on
family-centered practices. Set 2, "Services for Infants and
Toddlers," contains modules which emphasize the use of activity-based
approaches, natural environments, and assessment for early
intervention. Set 3, "Systems Support in Early Intervention,"
contains modules on teams and teaming, related laws, collaboration,
and collaborative consultation. (DB)

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Materials for Use by Faculty Who Teach about Infants and Toddlers with Disabilities

Training Materials prepared by the Northeast Institute for Faculty Training, 1993-1996

Introduction

The NorthEast Institute for Faculty Training

The NorthEast Early Intervention Faculty Institute linked professionals and parents across twelve states in parent/professional collaborations. The Institute training model was designed to address the need for training increased numbers of early intervention personnel across twelve disciplines. States included in Institute activities included Vermont, Maine, Rhode Island, Connecticut, Ohio, New Jersey, New York, Pennsylvania, Delaware, New Hampshire, and Massachusetts.

States training teams comprised of interdisciplinary faculty and parents devised training experiences responsive to the unique needs of their individual states. The Institute provided training for interdisciplinary regional faculty utilizing materials developed by the Institute. The overall teaching model was one of parent professional collaboration.

The Institute developed a set of three modules that interdisciplinary faculty can utilize in early intervention course-work. **Set One is Services for Families.** *This series contains the modules: Family Centered Practices and the Family Centered Practices Series.* **Set Two is Services for Infants and Toddlers.** *This series contains the modules: Increasing the number of learning opportunities for a child by using ACTIVITY BASED APPROACHES, Helping infants. toddlers. and young children to crow, learn and participate in their NATURAL ENVIRONMENTS, and Assessment for Early Intervention: New Purposes, New Practices.* **Set Three is Systems Support in Early Intervention.** *This set contains the modules: Infants and Toddlers with special needs and their families: Related Laws. Infants and Toddlers with Special Needs and their families: Teams and Teaming, Infants and Toddlers with Special Needs and their families: Collaboration, and Infants and Toddlers with Special Needs and Their Families: Collaborative Consultation.*

Introduction to the Project

A number of issues remain to be resolved as states develop and implement services under Part H of P.L. 99-457. Many states have required a longer time period than the five years specified in the original legislation to develop and institutionalize the policies and procedures necessary for full implementation. The two required components of the legislation that have not yet been fully addressed by states include those focused on personnel issues -- the Comprehensive System of Personnel Development (CSPD) and policies for personnel standards. These components are only two of the 14 required by Part H which must be addressed before full implementation is assured but represent a critical area (Campbell, 1990; Gilkerson, Hilliard, Schrag, & Shonkoff, 1987; Klein & Campbell, 1990; Meisels, Harbin, Modigliani, & Olson, 1988; Smith & powers, 1987; Woodruff, McGonigel, Garland, Zeitlin, Chazkel-Hochman, Shanahan, Toole, & Vincent, 1985).

Early intervention is facing a critical shortage of personnel trained to provide services under Part H (Meisels et al., 1988; Bailey, Simeonsson, Yoder, & Huntington, 1990). This shortage is expected to last well into the 1990's and includes both early childhood special educators and related service personnel (McCollum & Bailey, 1991). This shortage has resulted, in part, from the specialized requirements of infant/toddler service delivery under the new law. These requirements include the development of competencies and skills which are qualitatively different from the skills typically included in programs training personnel to work with school-aged or preschool-aged children (Bailey, 1989; Bailey, Farel, O'Donnell, Simeonsson, & Miller, 1986; Bricker & Slentz, 1988; Campbell, 1990; McCollum & McCarten, 1988; McCollum & Thorp, 1988: Thorp & McCollum, 1988). For example, the law requires that professionals from multiple disciplines be trained to assess infants and toddlers collaboratively; identify family priorities, concerns, and resources; develop an individualized service plan in tandem with families; and assist families to obtain and coordinate desired services. In particular, the family focus is unique to this age group, and demands additional skills beyond the traditional child focused intervention skills.

The lack of available, well trained personnel is compounded by a lack of professional standards specific to early intervention services (Gallagher & Staples, 1990). The requirement in P.L. 99457 for professional standards across ten disciplines has not yet resulted in any nationally adopted requirements. Only two states (New Jersey and Idaho) have adopted standards across a majority of the disciplines, and these standards do not contain competencies specific to infants and toddlers (Bruder, Daguio, & Klowsowki, 1989). Many states are planning to address licensing requirements but there is no guarantee that these requirements will meet specific infancy and interdisciplinary competencies necessary to work effectively within the family-centered model outlined in the legislation.

A number of states have examined the current status of training programs for professionals specializing in early intervention and a number of national studies have been undertaken. A survey of 260 undergraduate programs in special education found that 48% of them did not offer course work on interdisciplinary training (Courtnage & Smith-Davis, 1987). Likewise, Bailey and his colleagues (Bailey, Palsha, & Huntington, 1990) at the North Carolina Personnel Preparation Institute surveyed both undergraduate and graduate programs for all ten early intervention disciplines: special education, nursing, occupational therapy, speech and language pathology, physical therapy, audiology, medicine, case management, nutrition, and social work. They examined the number of clock hours of training content focused on areas related to delivery of early intervention services including case management, ethics, infant development, infant and family assessment, team processing, and values. Their results suggested a significant lack of preparation within these areas across all levels of higher education (e.g., undergraduate through doctoral study) and a willingness of faculty to infuse early intervention content into existing course work if training materials were available. Few programs indicated an interest in or feasibility to develop new programs or tracts designed to train personnel for employment in early intervention. Additionally, a lack of consensus over the type and number of competencies that should be exhibited by trainees existed in those higher education personnel preparation programs which specifically trained infant specialists.

Several state-level Interagency Coordinating Council (ICC) personnel preparation groups have undertaken state studies following the model used by Bailey and his colleagues. The Louisiana Personnel Preparation Consortium Project for Part H replicated the telephone survey protocol from the North Carolina Personnel Preparation Institute in conducting a state-wide survey of para-professionals through doctoral training programs in the ten early intervention disciplines (Sexton & Snyder, 1991). Their results replicated those found reported by Bailey and his colleagues (1991). The content areas that received the least amount of time across all surveyed programs were information about the law, infant intervention, and family assessment. Infant development received the greatest amount of time across all disciplines while

some areas, such as case management, were not addressed at all in the programs of many disciplines. Results of the Louisiana study indicated that few colleges or universities were planning on developing a separate infant/family training track and that most faculty were interested in infusing content related to infants and families within existing course work. These faculty indicated a willingness to use developed training modules or telecommunications technology (if such a vehicle were possible). Another in-depth study was conducted by Hanson and colleagues (1991) of personnel training needs in California. This study further documented the limited amount of time spent in pre-service training programs on early intervention content and the significant needs for increased activity at both the pre-service and in service levels.

Early intervention training requires a two-prong approach--one of which is to ensure an increased number of available personnel through alterations or development of pre-service training programs and the second of which is the need to retrain existing personnel at the in service level (McCollum & Bailey, 1991). This retraining is of particular importance in early intervention as states develop systems or alter existing systems to make them family-centered. Existing personnel will require training not only on the components of the "new" system but also on particular content areas such as families, evaluation and assessment procedures, interdisciplinary service provision, and case management (e.g., service coordination). In addition, values and procedures for reflecting sensitivity to cultural values and for intervening with particular groups of families and infants (e.g., HIV+/AIDS; technological dependence) will be required (Campbell, 1990).

In service education has been defined as the process by which service personnel are provided experiences designed to improve or change professional practice (Bailey, 1989). Generally, the objectives of in service training include the changing of attitudes, the acquisition of new knowledge, and the development and enhancement of technical skills (Laird, 1985; Bernstein & Zarnick, 1982). The desired outcome of in service training is for the participants to internalize new knowledge and apply what has been learned to their specific professional need (Barcus, Everson, & Hall, 1987).

The vast majority of in service training is not conducted in accordance with known best practices and subsequently is ineffective (Guskey, 1986). One method to enhance acquisition is to provide support and coaching to assist participants to transfer what they have learned to daily practice. Follow-up coaching is essential to the training process (Joyce & Showers, 1982). A review of in service practices indicated that continued support and follow-up after initial training is critical and should include ongoing guidance and directions to facilitate adaptations to new

situations (Guskey, 1986).

The implementation of staff development programs should be planned carefully to incorporate effective in service procedures which are designed from an ecological perspective. This means that all members of a staff, including administrative personnel, should be a part of the training efforts so that effecting change in other team members does not become the responsibility of one member of the team. Furthermore, in order to be effective, training must be based on the needs and values identified by the trainees. A match is needed between information that is presented and that which is desired, so that new information and skills will be put into use within the early intervention process.

Within intervention programs, staff development must become part of ongoing responsibilities for each team member. This requires allocation of time and resources from the intervention program or agency to provide staff the opportunity to develop self identified skills. Not only should goals be individualized for each staff member, but the process for reaching those goals also should be individualized. Plans may incorporate a variety of options for training as diverse as workshop attendance, college course work, learning from a mentor or videotaped materials. Staff development is a process which takes place over time.

Training of existing practitioners is most effective when individuals are motivated to take an active part in identifying and reaching their own goals and when there is adherence to the principles of adult learning. These principles are derived from Knowles (1980) and include:

1. *The need to know.* Adults will learn more effectively if they understand why they need to know certain information, or why they must have the ability to perform particular skills. Adult learners must be able to see that the benefit of learning a skill will outweigh the cost of the time and effort it takes to learn it. The more adults can see the benefit to learning, the stronger they will feel the "need to know "

2. *The need to be self directed.* As people mature into adulthood, they have a deep psychological need to be responsible for their own lives. Cultural conditions will obviously enhance or retard this process, but there comes a time in the psychological development of adults when they "feel like an adult." Adult learners are more successful if they can take responsibility for their own learning.

3. *The importance of experience.* Adults by virtue of their age and life experiences, bring a vast amount of knowledge and a wide variety of experiences with them to the classroom. This wealth of

life experience can result in the following consequences for the training program:

> a. Groups of trainees will have wide and varied backgrounds, therefore, the training staff will have to individualize instruction;
> b. Adults are a rich source of information for themselves and the other trainees because of their experiences. The training staff should take advantage of these experiences by using techniques such as group discussion and brainstorming;
> c. Adults may have some rigid ways of thinking that consequently interfere with learning. The training staff may need to "unfreeze these ways of thinking through activities such as sensitivity training or values clarification.

4. *The readiness to learn.* Adults will learn the things that they perceive will bring them greater satisfaction or success in life. As adults move through various stages of psychological and social development, their readiness to learn is reflected accordingly. For example, adults are interested in learning job specific skills when they acquire a job. As a result, it is important for the training staff to understand that learning opportunities should be offered in a timely fashion on topics of immediate value.

5. *Orientation to learning.* Adults see the reason for learning as acquiring competencies that will enable them to cope more effectively with life, perform life tasks and solve real problems. Training staff need to organize trailing programs around real world issues that confront adults from day to day.

These principles will provide a foundation within all Institute activities related to training faculty to train early intervention practitioners. While one emphasis of the Institute's training is to provide information about early intervention for future practitioners, the majority of training by trained faculty will be directed toward interdisciplinary early intervention practitioners.

Competencies Required of Early Intervention Personnel

Professional organizations (e.g., Dunn, Campbell, Oetter, Hall, & Berger, 1989; McCollum, McLean, McCarten, & Kaiser, 1989; Wilcox et al., 1989) as well as recognized leaders in early intervention personnel preparation (e.g. Bailey, 1989; Fenichel & Eggbeer, 1990; Hanft & Humphrey, 1989; Hanson & Lynch, 1989; Klein & Campbell, 1990; McCollum & Thorp, 1988) have recommended specific competencies for professionals employed within

early intervention. Some states have conducted their own studies and identified lists of competencies (e.g., California; Florida). Although many articles and listings of competencies have been produced, there is little agreement on an established number of competency areas or on specific competencies themselves. For example, an examination of federally funded personnel preparation programs for interdisciplinary infant specialists found that there was a range of 7 to 380 training competencies to be demonstrated by trainees within the 40 federally funded programs (Bruder & McLean, 1988).

The number of competencies expected of early intervention personnel will depend directly on the model used for establishing indicators. For example, if competency statements are to serve as a basis for measuring student or trainee performance, there are likely to be a greater number of competencies than if competency statements are designed around a taxonomy structure of knowledge, skills, and attitudes (Campbell, 1990). Furthermore, the extent of competency required by practitioners will vary dependent on the availability of personnel and the philosophical structure underlying the training activity. Clearly, a number of content areas are important for all practitioners including: (a) cultural sensitivity; (b) family-centered philosophy and concepts; help giving behavior; (d) team functioning and participation; and (e) knowledge of early intervention program legislation, regulations, and state standards and practices. In addition, practitioners need to have knowledge of discipline-specific content as applied to infants and toddlers and as delivered within a family-centered perspective.

Those competency lists and descriptions that have been generated by professional organizations reflect an emphasis on discipline-specific areas (e.g., OT; early childhood special education). Those that have been generated by training programs reflect the specific behaviors that trainees will demonstrate following completion of the course of study. A more broad-based and encompassing discussion of competency has been generated through the Training Approaches for Skills and Knowledge (TASK) project which generated areas of competence necessary for professionals of all disciplines to demonstrate when working with families and infants and toddlers, regardless of the at risk or disability status of the infant or toddler (Fenichel & Eggbeer, 1990). The TASK list includes the following core concepts for professional practice with infants, toddlers, and their families: (a) endowment, maturation, and individual differences; (b) the power of human relationships; transactions between the infant and the environment; (d) developmental processes and their interrelationship; (e) risk, coping, adaptation, and mastery; (f) parenthood as a developmental process; and (g) the helping relationship. These conceptual areas are important at all levels of pre-service and in service training and will be used as a basis for determining the specific

competencies that will be developed in practitioners trained by faculty who are trained through the Institute's activities.

A Model for State-Wide Pre-service and In service Training

The Northeastern Early Intervention Training Institute links professionals and parents together across the 12 state region in parent-professional collaborations to provide three levels of training for current and future early intervention practitioners of all ten early intervention disciplines. These individuals, in turn, are linked with the Part H coordinators within their states and across the region. Inherent within the Institute's model is this state-wide and regional linkage of parents, professionals, and policy makers and of Institute staff with users of Institute training "products." the training model, itself, includes three areas: (a) needs assessment; (b) training of interdisciplinary faculty; and training of early intervention practitioners. Procedures and materials for training faculty who, in turn, will train practitioners using Institute developed procedures and materials will be field-tested within each of the states within the region by parent-professional training teams. These materials and the training procedures will be shared with other regional training Institutes and will be used by faculty on an ongoing basis through links with Higher Education Councils that will be developed for early intervention within each state in the region.

Importance

The need for training increased numbers of early intervention personnel across all ten disciplines that make up services for infants, toddlers, and their families have been well documented in state reports, training research studies, and by professional organizations and leaders. Furthermore, states have reported additional needs for retraining existing personnel working within early intervention as they begin to carry out the family-focused state-wide systems of early intervention and, in particular, the required components that relate to programmatic issues. Major programs such as the North Carolina Personnel Preparation Institute as well as individual efforts of state Interagency Coordinating Council (ICC) personnel preparation task forces indicate that training faculty who will, in turn, train future and existing early intervention personnel may be one strategy that can impact significantly upon both the quantitative and qualitative training needs in early intervention

The purpose of this project is to develop and implement a faculty training institute for early intervention personnel in 12 states in the northeastern region of the United States (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Vermont). The organizational design for the Institute links Part H coordinators and parent and professional consultants together in each state and as a regional group to develop procedures and materials for training interdisciplinary faculty across the region to provide three types of training in key content areas for personnel representing the ten early intervention disciplines. Faculty will be trained to infuse basic early intervention content into existing course work, develop new course work or modify existing course work to include critical areas of early intervention content, and provide periodic in service training that results in continuing education credits. Materials and procedures for training state faculty and for use by state faculty in training early intervention practitioners will be developed and validated by Institute staff using a process that directly links the users with the developers. Content areas for all three types of training will be determined on the basis of a needs assessment which will identify the status of preservice training programs as well as content areas of need as determined by surveying early intervention practitioners.

Activities are designed to impact on both the quantity and quality of early intervention personnel across the ten disciplines by conducting training and by establishing or strengthening existing Higher Education Council structures within each state in the region. It is anticipated that these Councils will be linked to each state's ICC through the individual who serves as the higher education representative on the Council and through personnel preparation task forces, in states where these groups exist. Establishing these Councils provides an ongoing vehicle for delivery of ongoing training by faculty within each state. Training activities will be directed to 3~ identified faculty within a particular state. It is anticipated that the majority of faculty will participate in the infusion training and that selected faculty will receive training designed to assist them in developing new or altering existing course work to focus more directly on early intervention content areas. Some of the faculty from both of these training groups also will complete in service training and will serve as resources to the Part H coordinator and state ICC for regional or state-wide training initiatives. The Institute is designed to undertake the following functions: (a) model development and validation including conducting the needs assessment each year of the Institute; (b) conducting faculty training including the development and validation of training materials; overseeing the implementation of training for future and existing early intervention practitioners including development and validation of procedures and materials for use by faculty; (d) evaluation; (e) dissemination; and (f) management and administration. These functions will be accomplished by Institute staff, parent and interdisciplinary professional consultants who are leaders in early intervention within their own states, and Part H coordinators.

Impact
of this Faculty Training Institute

This inservice Institute expands the knowledge-base on early intervention training methods in a number of ways. Primarily, the Institute has developed a consortium of higher education faculty, Part H policy makers and parents to jointly develop training content and methodology in early intervention across 12 states in the northeast (CT, DE, MA, MD, ME, NH, NJ,NY, OH, PA, RI, VT). This consortium has assisted in the implementation and evaluation of the Institute, thus increasing the likelihood of long-term commitment to the Institute.

Secondly, the Northeastern Faculty Training Institute has designed in-service training options that are consistent with the literature on adult learning, thus increasing the effectiveness of the training. That is, the inservice training is individualized to accommodate the needs of both faculty and direct service staff in all 12 states. Third, the Institute has developed, implemented and evaluated a variety of training methods and procedures for use by higher education faculty within colleges and universities in each of the 12 states. Fourth, the Institute has developed and is disseminating a number of training manuals and modules for use with multiple audiences involved in early intervention. Fifth, the Institute has coordinated training across each of the 12 states, thus ensuring that early intervention programs, families and their children in the northeast will benefit from having more knowledgeable and skillful interdisciplinary early intervention personnel. Finally, the Institute has collaborated with other funded projects to maximize coordination across the county.

A series of training activities were planned in order to reflect the needs and preferences of individual states as well as maximize the number of faculty and early intervention practitioners who were trained during the three year duration of the Institute. The Institute's activities will impact both on faculty who are trained as well as the individuals trained by them within their states. All of these training activities were evaluated to determine

the immediate and longer term effects on participants and, in the case of practitioners, on the children and families served by them. These data serve to ensure the systematic refinement of both program components and training activities as well as provide a direct measure of both quantitative (i.e., numbers of individuals trained) ad qualitative (i.e., how well those individuals did with training) effects of the Institute's training activities.

A broader audience will be impacted upon through broad-based dissemination activities. The purpose of the dissemination component of the Institute is to translate project findings (e.g., studies and evaluation data) into products, training content, and service delivery practices. All materials and procedures developed will be disseminated through a variety of channels within the region including regional resource centers,University Affiliated Programs (UAPs), professional organizations (e.g., DEC),and other OSEP funded or state funded training projects.

There is an accumulating amount of literature on adapting or implementing educational innovations or service models. Inherent in any type of service delivery model is the premise that services should ultimately be evaluated on the basis of their benefits to consumers (in this instance young children and their families). Additionally, it has been suggested that innovations within service delivery undergo a development process in which the delivery techniques are defined as procedures, materials, rules, activities or other environmental changes which change the behavior of one or more persons. A collection of intervention techniques and administrative arrangements which contribute to behavioral changes across individuals is illustrative of a demonstration. The model is the prototype for replication of the demonstration across service settings, consumers, and administrative arrangements (Paine, Bellamy, & Wilcox, 1984). During each of these service applications the processes for development and dissemination are quite different.

This Institute represents the refinement of techniques and the development of a demonstration aimed at changing the behavior of both faculty members and services providers through the delivery of training. We provide information for adaptation of intervention to fit the user's purpose. In the case of this training Institute, the users are Part H policy makers and faculty members involved in the development and delivery of training. We also generate support for the involvement of faculty in the delivery of training specific to the early intervention system in each of the 12 states through a variety of adaptable methods.

Jummary of the The NorthEast Institute for Faculty Training Materials:

▶ **Services for Families:** *Family Centered Practices and the Family Centered Practices Series.*

▶ **Services for Infants and Toddlers:** *Increasing the number of learning opportunities for a child by using ACTIVITY BASED APPROACHES; Helping infants, toddlers, and young children to grow, learn and participate in their NATURAL ENVIRONMENTS; and Assessment for Early Intervention: New Purposes, New Practices.*

▶ **Systems Support in Early Intervention:** *Infants and Toddlers with special needs and their families; Related Laws. Infants and Toddlers with Special Needs and their families; Teams and Teaming, Infants and Toddlers with Special Needs and their families; Collaboration, and Infants and Toddlers with Special Needs and Their Families; Collaborative Consultation.*

Information about Institute activities or the modules can be obtained by contacting Lisa Leifield at Temple University (215) 204-1396.

Modules

Family Centered Modules
- o Comprehensive Programs and Policies*
- o Racial, Ethnic, Economic, and Socioeconomic Diversity*
- o Developmental Needs*

Services for Infants and Toddlers
- o Natural Environments
- o Activities and Routines
- o Integrated Therapy

System Supports in Early Intervention
- + Law
- + Teams
- + Collaboration
- + Consultation

SERVICES FOR INFANTS AND TODDLERS

Increasing the number of learning opportunities for a child by using ACTIVITY BASED APPROACHES TO INTERVENTION

Author: *Mary Beth Bruder*

This module is designed to provide information of the application of the activity based approach to early intervention. Professionals need to take advantage of the hundreds of learning opportunities present within a child's daily routines and activities. This module describes the activity based approaches to intervention, defines the role of the interventionist, and describes the techniques used to implement activity based interventions. By the end of the module, the participant will be able to:

1) Describe activity based approaches to intervention;

2) Define the role of the interventionist;

3) Describe the techniques used to implement activity based intervention interventions.

Helping infants' toddlers, and young children to grow learn, and participate in their NATURAL ENVIRONMENTS

Author: *Mary Beth Bruder*

Professionals need to understand the impact that the learning environment has on both the child and the family. This module contains information on the importance of early intervention within natural environments. The module defines the term natural environment, describes the types of services that can be successfully delivered in natural environments, and describes the techniques for designing intervention in natural environments. By the end of the module the participant will be able to:

1) Describe types of natural environments in which early intervention services could occur;

2) Provide a rationale for the delivery of early intervention services in natural group environments;

3) Describe service delivery parameters for providing early intervention in the home;

4) List examples of interventions that could occur within a family's home and natural group environments;

5) Describe naturalistic teaching strategies on embedding a child's developmental goals into activities and routine within natural group environments.

Assessment for Early Intervention: New Purposes, New Practices

Author: *Jack Neisworth*

The purpose of this module is designed to offer fundamentals of assessment for early intervention. The content of the module is an orientation to the issues and recommended practices rapidly emerging in the field. Resources are listed at the end of the module that will allow those interested to pursue the topic in depth. This module contains

information on the basic elements of assessment, factors covered in assessment, issues related to conventional assessment, assessment methods, and assessment standards. By the end of the module the participant will be able to:

1) State the basic definition of assessment;

2) Identify the major decisions that assessment helps us make;

3) Describe four major factors or dimensions that are addressed;

4) Describe issues and problems related to conventional assessment of infants and toddlers;

5) Explain norm, curriculum, performance, and ecological based assessment;

6) Explain how curriculum-based assessment is ideal for program planning and monitoring;

7) Describe team models and arrangements for assessment;

8) State options for eligibility assessment;

9) Describe the four major standards for assessment;

10) Describe the strength of convergent assessment.

SERVICES TO FAMILIES

Infants and Toddlers with special needs and their families: The importance of the Family

Author: *Louisiana State Interagency Coordinating Council Personnel Preparation Subcommittee, December, 1991.*

This module provides information on factors that affect family functioning, the professional family relationship, ecological/family systems theory, and the family centered approach to working with families of infants and toddlers with special needs. At the end of the module the participant will

be able to:

1) Provide a functional definition of the family.

2) Identify factors that affect family functioning.

3) Identify trends in professional conceptualizations of families and of professional/family relationships.

4) Discuss the rationale for, and issues in, family centered intervention approaches.

5) Describe the key elements of an ecological model of human development and of family systems theory.

Family Centered Practice Overview

Authors: *Philippa Campbell and Lisa Leifield*

This module is organized as an hour long session designed to provide participants with an overview of family centered principles. The information in this module expands upon the concepts of family-centered approaches that was introduced in the module entitled The Importance of Family. Nine family centered principles are outlined in the module including:

1) Recognizing that the family is the constant;

2) Family professional collaboration;

3) Honoring diversity;

4) Recognizing family strengths and coping styles;

5) Sharing with parents complete and unbiased information;

6) Encouraging and facilitating family to family support;

7) Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into health care systems;

8) Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families; &

9) Designing accessible health care systems that are flexible, culturally

competent, and responsive to family identified needs. By the end of the module the participant will be able to:

1) List and define the nine principles of family centered care;

2) Describe one activity or strategy that characterized each of the nine family centered principles.

Family Centered Practice Series

Authors: *Pip Campbell & Lisa Leifield*

Recognizing that the family is the constant in a child's life while the service system and personnel within those systems fluctuate. Family members remain the constant in their children's lives while professionals' associations with families are likely to be episodic and short-term. The purpose of this module is provide an overview of the factors that remain constant in families and the implications for practice. By the end of the module the participant will be able to:

1) List and describe the ways that professionals can support parents in their roles as decision- makers, care givers, advocates, and nurturers. and;

2) Provide two examples of the ways that professionals can support and not supplant families in their rules.

Facilitating family professional collaboration at all levels of health care

Family centered practice can be implemented within all aspects of the service system when parents and professionals work together. Collaboration requires mutual respect, trust, and an equal partnership between parents and professionals. The purpose of this module is to review the principles of collaboration that facilitate effective parent professional partnerships. By the end of the module the participant will be able to:

1) Define enablement and empowerment;

2) Identify and provide examples of behaviors affiliated with an enablement model of helping;

3) Identify and provide example of the principles of collaboration.

Honoring the racial ethnic, cultural. and socioeconomic diversity of families.

The population of the United States is becoming more diverse. The purpose of this module is to provide information about the ways in which professionals can acknowledge the cultural traditions, values, and diversities of families and understand their relationship to the provision of early intervention services. By the end of the module the participant will be able to:

1) Identify the dimensions of culture that impact on the provision of early intervention services;

2) Acknowledge the cultural traditions, values, and diversities of families and recognize their importance within early intervention services.

Recognizing family strengths and individuality and respecting different methods of coping

The purpose of this module is to provide information about the strength of families and coping styles and strategies that families utilize to cope with day to day events as well as crisis situations. By the end of the module the participant will be able to:

1) Identify and describe five of the twelve qualities of strong families;

2) Identify and provide examples of types of coping strategies.

Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information

Family identified needs and concerns are more likely to be addressed when families and professionals share information in a complete and unbiased way. The purpose of this module is to review the functions of sharing information, the dimensions of sharing information, and the different ways that information can be shared with families. By the end of the module the participant will be

able to:

1) Identify the function of sharing information and provide examples of each of the functions.

2) Identify the dimensions of sharing information and provide examples of ways in which professionals can share information in family centered ways.

Encouraging and facilitating family to family support and networking

Parents of children with delayed development or disabilities may benefit from meeting and learning with other parents in similar circumstances. Veteran parents, those whose children are older or who have survived medical or health problems, often provide friendship, knowledge, support, and information from parents less experienced with raising a child with special needs. The purpose of this module is to review the function of family to family support, the forms of family to family support, strategies to facilitate family to family support, and examples of informal and formal support. By the end of the module the participant will be able to:

1) List and provide examples of the functions of family to family support;

2) List and provide examples of the forms of family to family support.

Understanding and incorporating the developmental needs of infants. children and adolescents and their families into health care systems

All aspects of a child's development are integrated. However, many existing services focus on only one aspect of a child's or family's life. The compartmentalized approach inherent in service systems often results in fragmented service delivery. The purpose of this module is to review the importance of providing services in an integrated manner. By the end of the module the participant will be able to:

1) Describe ways in which professionals can create opportunities to address developmental, as well as the other, needs of children;

2) Describe ways in which professionals can create opportunities to

support adult development and learning.

Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families

Service provision in early intervention is reflective of a broad based family support movement to ensure that services for all families are more comprehensive, culturally responsive, and supportive. The purpose of this module is to review the reasons for comprehensive services, types of comprehensive services, and procedures for the determination of family concerns, needs, & priorities. By the end of the module the participant will be able to:

1) Identify and provide an example of five different types of comprehensive services;

2) Discuss characteristic of families and the implications of the characteristics when planning for comprehensive services.

Designing accessible health care systems that are flexible, culturally competent and are responsive to family-identified needs

Systems and services that are flexible, accessible, and responsive to families needs are those that are using family centered practices. Allowing families to choose the services they wish to receive and to decide how often and where services best can be provided enables families to utilize services without compromising family priorities and functions. The purpose of this module is to provide and overview of the strategies to make systems flexible, culturally responsive, and culturally competent. By the end of the module participants will be able to:

1) List and provide examples of strategies to make systems more flexible and accessible;

2) List and provide examples of strategies to make system more responsive to family identified priorities and needs.

SYSTEMS SUPPORT IN EARLY INTERVENTION

Infants and Toddlers with Special Needs: Teams and Teaming

Author: *Louisiana State Interagency Coordinating Council Personnel Preparation Subcommittee, December, 1991.*

Teams are valued by professionals in early intervention settings and are strongly supported in early intervention legislation and regulations at the federal and state level. The purpose of this module is to provide an overview of the functions of teams, structures of teams, and the value and importance of including families as equal team members on early intervention teams. By the end of the module, the participant will be able to:

1) Describe the functions and structure of the team within early intervention;

2) Identify each of the professionals that may be included on a team and describe the role of each professional;

3) List at least three ways to facilitate equal participation of families as members of teams;

4) Describe typical team activities;

5) Identify the incentives and disincentives that relate to productive functioning of teams;

6) Describe the benefits of team participation for families, professionals, and children.

Infants and Toddlers with Special Needs and Their Families: Related Laws

Author: *Louisiana State Interagency Coordinating Council Personnel Preparation Subcommittee, December, 199 1.*

A unique feature of early intervention services for infants and toddlers with disabilities and their families is the important role that state and federal legislation has played in establishing the importance of early intervention, providing incentives for services, and establishing regulations

that guide and shape practices. This module presents information on major legislation related to young children with disabilities and their families as well as examining the values which underlie the legislation. By the end of the module the participant will be able to:

1) Describe the major federal legislation related to services for young children with disabilities and their families;

2) Describe the major provisions of P.L.99-457;

3) Describe the major themes that underlie current legislation for young children with disabilities and their families;

4) Describe current laws and systems of services for infants and toddlers with disabilities and their families.

Infants and Toddlers with special needs and their families: Collaboration

Author: *Northeastern Early Intervention Faculty Institute*

Collaboration between individual service providers is a central component of early intervention service provision. Numerous reasons have been provided for collaborative service delivery including improvement of service delivery, reduction in service duplication, and links among families and professionals for efficient service utilization. This module provides an overview of the rationale for collaboration in early intervention, barriers to collaboration, conflict management styles, and conflict resolution strategies. By the end of the module the participant will be able to:

1) Provide a rationale for collaboration in early intervention;

2) Describe the barriers to collaboration;

3) Describe ways in which individuals manage conflict during collaboration;

4) Identify the types of conflict management style used by an individual;

5) Describe ways to resolve conflict.

Infants and Toddlers with Special Needs and their families: Collaborative Consultation

Author: *Northeastern Early Intervention Faculty Institute*

A variety of consultation models have been utilized to provide services for children with disabilities. The purpose of this module is to review the reasons why consultation models are utilized and examine the factors that facilitate effective consultation. By the end of the module the participant will be able to to:

1) Provide a rationale for consultation in early intervention;

2) Define collaborative consultation;

3) Describe principles of collaborative consultation;

4) Describe strategies to use during collaborative consultation;

5) Provide examples of collaborative consultation.

Biographies Northeastern Early Intervention Institute Staff

Angela Capone, Ph.D.

Angela Capone, Ph.D. is Coordinator of Early Childhood Programs at the University Affiliated Program of Vermont, and is an assistant professor in the Department of Integrated Professional Studies. Dr. Capone's expertise lies in the areas of child development, a constructivist approach to designing early childhood programs for infants, toddlers, and preschoolers, and parent-professional partnerships. Dr. Capone currently directs an early intervention specialist personnel preparation program, and a National Outreach project focusing on system change and the implementation of "best practice" in the provision of services for young children and their families.

Pip Campbell, Ph.D., OTR.L.

Pip Campbell, Ph.D., OTR.L, is an occupational therapist and special educator whose interests relate to families, infants and toddlers, and children with severe disabilities. Dr. Campbell is currently an associate professor Curriculum, Instruction, & Technology in Education in the College of Education at Temple University.

Dr. Campbell currently directs several demonstration and research projects related to infants, toddlers, and young children with special needs and their families. Dr. Campbell formerly directed the Family Child Learning Center in Ohio, an early intervention and preschool service-training- research program that was operated jointly by Children's Hospital and Kent State University where innovative programs for families and their young children were developed and delivered. The Center's programs provided research-based interventions for typical children as well as a number of regional or

state-wide activities including the state-wide parent to parent support network, the Family Information Network, the state-wide training team for Early Intervention, and the Technology Training Program, an on-site and individualized training program for teachers and related services personnel.

Mary Beth Bruder, Ph.D.

Mary Beth Bruder has been in early intervention for the past 20 years. She began her career as a preschool special educator in Vermont and since then has been involved in the design, provision, and evaluation of early intervention services within five states. She received her Ph.D. from the University of Oregon and currently she is the Director of the Division of Child and Family Studies at the University of Connecticut Health Center. She is also an Associate Professor of Pediatrics at the University of Connecticut. She directs a number of preservice, inservice, and direct service early intervention projects in both New York and Connecticut.

Other Institutes include...

The Midwestern Consortium for Faculty Development

The Midwestern Institute for Faculty Training was a Part H training project serving thirteen Midwest states: North Dakota, South Dakota, Missouri, Nebraska, Oklahoma, Texas, Kansas, Michigan, Indiana, Minnesota, Iowa, Wisconsin, and Illinois. The Consortium's activities were intended to assist faculty from institutions of higher education in the training of early intervention personnel from a broad range of disciplines in a number of competency areas including working with families, teaming, service coordination, and problem solving.

The Consortium was committed to responding to the individual needs and circumstances of each state in order to work together to build upon existing resources and expertise. Training activities were developed within the context of a family-centered philosophy and were interdisciplinary and interagency in nature.

The Consortium engaged in a variety of activities over a three year period including provision of summer training activities, provision of individualized state training plans for states within the region, and state minigrants for assistance with implementation of state training plans. A regional information exchange center was also established at the University of Minnesota to facilitate the exchange of information and resources within the region.

Information about Consortium activities can be obtained by contacting Marti Smith, Institute on Community Integration, University of Minnesota, (612) 624-3567.

The Southeastern Institute for Faculty Training

The Southeastern Institute for Faculty Training SIFT has developed, implemented, and evaluated a systems change model, designed to make a long lasting and meaningful impact on state-level early intervention efforts. It was funded to serve the 15 jurisdictions of the southeastern region. The specific goals of this project have been (1) to facilitate

the personnel preparation linkages between institution of higher education and state agencies; (2) to increase higher education faculty members knowledge and skills related to early intervention content and instructional strategies; and (3) to assist faculty in applying what they learn to the preservice and inservice training they provide to others.

Analysis of data from SIFT participants has documented the following benefits (1) statistically significant increases in faculty knowledge and skill in early intervention content and training strategies (2) greater faculty commitment to participating in community based inservice and technical assistance activities (3) preservice and inservice training that is of higher quality; (4) increased linkages between state agencies, institutions of higher education, and consumers around personnel preparation at the state level. In summary, the project has increased the chances that quality support and training in Part H content is available at the community, regional and state level.

Products developed by SIFT include a 143-page annotated Resource guide to early intervention training materials. The SIFT model will be available in late 1995 to select states as SIFT OUT through an outreach grant. **For information about SIFT or SIFT-OUT contact Pamela Winton (phone: 919/966-7180 fax: 919/966-0862 E-mail: winton.fpgsm@mhs.uncedu) or Camille Catlett (phone: 919/966-6635; fax: 919/966- 0862; E-mail catlett.fpgsmgmhs.unc.edu).**

The Western Region Faculty Institute for Training

The Western Region Faculty Institute for Training is part of a national effort to expand and improve training of early intervention service providers through training and technical assistance for faculty in institutions of higher education. The WRFIT is founded upon current values and best practices in early intervention, particularly family-centered approaches, teaming and collaboration at multiple levels, and community-based services and supports for infants/toddlers and their families. The region covered by the WRFIT includes: New Mexico, Colorado, Wyoming, Montana, Idaho, Utah, Arizona, Nevada, California, Oregon, Washington, Alaska, Hawaii, American Samoa, Guam, Northern Mariannas, and Palau.

The WRFIT has provided technical assistance services and funding to individual faculty and to state planning teams in the western region to support their efforts to expand and improve birth-to-three teaching activities. Technical assistance has included: provision of resource

guides and curriculum reviews, telephone and on-site consultation, curriculum development assistance, training consultation, faculty needs assessments, WRFIT Newsletter, joint planning for faculty training events, provision of faculty "mini-grant" program, and faculty leadership conferences and retreats. Planning teams from every jurisdiction in the region have collaborated with the WRFIT to tailor efforts to local conditions and priorities. To date, 30 mini-grants have been issued. A summary of the cumulative accomplishments of the mini-grant program is in preparation.

The WRFIT is disseminating a number of original products in the area of early childhood personnel preparation as listed below. Basic information is included with the list. **If needed, more information can be obtained from Cheri Wheeler (303-270-6533; e-mail: WheelerC@titania.uchsc.edu). The cost of the products is either "no charge" or our cost of production; we can accept a check or purchase order or we can send products with an invoice.**

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4. Transparency Samples

Infusion Modules

Infants and Toddlers with Special Needs and Their Families

- Related Laws

NORTHEASTERN EARLY INTERVENTION FACULTY TRAINING INSTITUTE

The modules included in this notebook were developed for the purpose of providing preservice students with information about the field of early intervention. Many students are unaware of the possible employment opportunities in early intervention. Recent data indicate shortages for practicing professionals of all disciplines.

We are pleased to share this information with you through your state's Early Intervention Faculty Training Team. This group of parents and professionals have identified content areas of interest to faculty. The modules included in this notebook represent the topic areas selected for initial training.

Two evaluation forms follows this introduction. When you infuse any of the modules into existing courses or training opportunities, we would appreciate your completing the evaluation form. An evaluation form that can be copied to determine student satisfaction and general learning after participation in the module is included, also. We would appreciate your copying these evaluation forms, distributing to and collecting them from students, and sending them to the Institute Coordinator, Lisa Leifield. We will compile and summarize the student data and send you a summarization report.

There are 12 states that are participating in the Northeastern Early Intervention Faculty Training Institute. Each state team includes a parent of a child with a disability, at least one professional, and the state's Part H coordinator. Together, these individuals are working to provide training and technical assistance, materials, and other support activities for faculty working within the state. Increasing awareness about early intervention opportunities is important as is the development of training opportunities at all levels of preparation. We hope that these materials will be useful to you and welcome your comments about additional content topics, instructional suggestions, and other activities.

Please Send Completed Faculty and Student Evaluation Forms To:

Lisa Leifield, Project Coordinator
9th Floor, Ritter Hall Annex
Temple University Center for Research in Human Development & Education
13th Street & Cecil B. Moore Avenue
Philadelphia, PA 19122

Northeastern Early Intervention Faculty Training Institute
FACULTY EVALUATION
Of Training Infusion Modules

College/University

Type of Training Program

Infusion Module Used

_____ Undergrad _____ Grad

Name of Course

Number of Students Enrolled

Is this course required for certification or eligibility for licensure in your state?

_____ yes _____ no

If required, what is the type of certification/licensure?

_____

Please rate the following statements:

	Strongly Disagree		Neutral		Strongly Agree
The layout and format of the module were easy to use.	1	2	3	4	5
I was able to use the module easily without a great deal of background preparation.	1	2	3	4	5
The module contents fit easily within the context of the course.	1	2	3	4	5
I feel that the participants/students learned from the module.	1	2	3	4	5
I feel that the participants/students enjoyed the presentation of the module contents.	1	2	3	4	5

Learning Activities

If supplementary learning activities were included in the module contents and if you expanded the length of the module by using one or more of the activities, please list each activity and rate the following responses:

Learning Activity

_____

	Strongly Disagree		Neutral		Strongly Agree
The written explanation for the activity was clear and easy to follow.	1	2	3	4	5
The activity was helpful in enabling the participants to understand the concepts introduced through the module.	1	2	3	4	5
I feel that the participants enjoyed the activity.	1	2	3	4	5
I feel that the participants learned from the activity.	1	2	3	4	5

Northeastern Early Intervention Faculty Training Institute
STUDENT EVALUATION

College/University   Infusion Module Used

---   _____ Undergrad _____ Grad
Type of Training Program

Name of Course   Content of Presentation

Please rate the following statements:

	Strongly Disagree		Neutral		Strongly Agree
The information presented was very interesting.	1	2	3	4	5
I learned something from this module that I did not know before.	1	2	3	4	5
I am interested in learning more about early intervention due to having participated in this class session.	1	2	3	4	5
I learned something that I can apply in my current or future employment and profession.	1	2	3	4	5

The three (3) most important things I learned are:

1. _____

_____

2. _____

_____

3. _____

_____

Thanks for taking the time to complete this evaluation!!

Infants and Toddlers With Special Needs and Their Families

Related Laws

INSTRUCTIONAL MODULE II

Infants and Toddlers With Disabilities and Their Families:

Related Laws

PART ONE

   I.   Objectives
   II.   Outline
   III.   Explanatory Materials
   IV.   Evaluation
   V.   Resource Material

Instructional Module II

Infants and Toddlers with Disabilities and Their Families: Related Laws

I.   **Objectives**

By the end of this module, the student should be able to:

A.   Describe the major federal legislation related to serving young children with disabilities and their families.

B.   Describe the major provisions of Public Law 99-457.

C.   Describe the major themes that underlie current legislation for young children with disabilities and their families.

D.   Identify major challenges and future directions in early intervention and service delivery.

[Transparency 1]

II. Outline

A. Major Legislative Landmarks in Early Intervention Services
   1. 1965: Project Head Start
   2. 1967: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
   3. 1968: Handicapped Children's Early Education Program (HCEEP)
   4. 1972: Economic Opportunity Act Amendment for Children with Disabilities in Head Start
   5. 1975: Public Law 94-142
   6. 1986: Public Law 99-457
   7. 1990: Public Law 101-476 - Individuals with Disabilities Education Act
   8. 1991: Public Law 102-119

B. Current Federal Requirements Regarding Services for Infants and Toddlers With Disabilities and Their Families
   1. Eligibility
   2. Individualized Family Service Plan
   3. A Coordinated Set of Services
   4. Child Find and Public Awareness
   5. Interdisciplinary Personnel

C. Major Themes Underlying Current Legislation
   1. Family-Centered
   2. Individualized
   3. Coordinated With Other Agencies and Professionals
   4. Normalization

D. Future Themes and Directions
   1. Rethinking Traditional Discipline Boundaries
   2. Redesigning Service Delivery Systems
   3. Training

III. Explanatory Material/Expansion of Module Outline

A unique feature of early intervention services for infants and toddlers with disabilities and their families is the important role that state and federal legislation has played in establishing the importance of early intervention, providing incentives for services, and establishing regulations that guide and shape practice. This information is important for students because it provides both a historical background for the evolution of services as well as an understanding of the current context of services. In addition, however, students need to be aware that legislation has been influenced by a set of values or goals that have helped determine the way in which early intervention services are organized. The following outline and supportive materials suggest one way in which this information might be conveyed to students.

A. Major Legislative Landmarks in Early Intervention Services

Federal legislation influencing early intervention can be traced back to the 1960's, extending through today. Students should be aware of the major legislative events; however this should be a relatively brief presentation. The more detailed presentation should focus on P.L. 99-457 and subsequent amendments. [*Transparency 2*]

1.   1965: Project Head Start [*Transparency 3*]

In 1965 Congress passed the Economic Opportunity Act and established project Head Start. Head Start was designed to serve young children ages 3-5 years from poverty environments, based on the assumption that "early intervention" could decrease the likelihood of school failure for these children. An array of services are provided in the program, including day care, developmental enhancement, medical and dental screening, family support, and nutritious meals. More than 11 million children have participated since its inception; approximately two-thirds are from minority groups. This law was especially significant because it represented the first national commitment to educating young children.

2.   1967: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

In 1967, EPSDT was established as part of P.L. 90-248. As a component of Medicaid, this program required all states participating in

Medicaid to provide early screening, diagnosis, and treatment for all children under 21 years who are eligible for Medicaid.

3. 1968: Handicapped Children's Early Education Program (HCEEP) [*Transparency 4*]

In 1968, P.L. 90-538 created the HCEEP program in order to establish model demonstration programs in early intervention. Because so few programs existed, the intent was to develop a variety of different service models, demonstrate that they could be implemented and were effective, and then train others to implement them. The hope was that demonstrating successful services would lead to the establishment of more services. Since that time nearly 600 projects have been funded covering a wide range of topics and serving many children. It has been called one of the most successful federal programs ever, and it still exists. More than 80% of the funded programs continue to operate even after their federal funding has ended.

4. 1972: Economic Opportunity Act amendment for children with disabilities in Head Start

In this year, Congress mandated that at least 10% of the children enrolled in Head Start must have some handicapping condition. This is very significant because it reflects the first national commitment to providing comprehensive services for a group of children with disabilities. Currently, approximately 13% of the children in Head Start have a disability. Most (66%) are classified as having a speech impairment. Very few children with severe or profound disabilities are served in Head Start.

5. 1975: Public Law 94-142 [*Transparency 5*]

In 1975 Congress passed the Education for All Handicapped Children Act. This law has been referred to as the equivalent of the Civil Rights Act for children with disabilities. Essentially it guaranteed a "free and appropriate public education" for every child with a disability ages 6 through 17 years. An Individualized Education Plan (IEP) was required, and students were to be served in the "Least Restrictive Environment." A number of procedural safeguards were established, including due process, to ensure that parents could get the

V. Resource Material

A. Brown, W. (1990). <u>Early intervention regulation: Annotation and analysis of Part H</u>. Horsham, PA: LRP Publications.

> Dr. Brown's text provides complete statutes, legislative history, and regulations, with analysis, for Part H.

B. Campbell; P. H., Bellamy, G. T., & Bishop, K. K. (1988). Statewide intervention systems: An overview of the new federal program for infants and toddlers with handicaps. <u>Journal of Special Education,</u> <u>22</u> (1), 25-40.

> The authors provide an overview of P.L. 99-457, Part H and the 14 required components of this statute. They present a description of states' efforts to plan and implement the Part H program with an intent to provide a comprehensive picture of national early intervention activities. They discuss potential challenges for individuals involved in developing and implementing statewide systems of early intervention services.

C. <u>Early Childhood Law and Policy Reporter</u>. (Available from LRP Publications, 747 Dresher Rd., Horsham, PA 19044)

> A comprehensive information and reference service regarding law and policy. Subscribers receive a full text of all reported documents as well as concise headnotes for each document. There also is an easy-to-use topical index, statutory/regulatory case trackers, and complete case tables. An annual subscription is $225.00.

D.   Early Childhood Report. (Available from LRP Publications, 747 Dresher Rd., Horsham, PA 19044)

Subscribers to the Early Childhood Report receive 12 monthly issues ($135 per year) in a newsletter format. These newsletters provide readers with up-to-the-minute information about policy and legislation affecting service delivery in early childhood special education. The November 1991 issue, for example, contains information related to P.L. 102-119, the most recent re-authorization of Part H of P.L. 99-457.

E.   Garwood, S. G., Fewell, R. R., & Neisworth, J. T. (1988). Public Law 94-142: You can get there from here! Topics in Early Childhood Special Education, 8 (1), 1-11.

The authors discuss P.L. 99-457 in the historical context of the implementation of P.L. 94-142. These authors summarize the provisions of the new law and discuss several issues that the field of early intervention needs to address during implementation of this new legislation.

F.   Garwood, S. G., & Sheehan, R. (1989). Designing a comprehensive early intervention system: The challenge of P.L. 99-457. Austin, TX: PRO-ED.

Drs. Garwood and Sheehan present a brief, yet thorough, description of P.L. 99-457, Part H. In Chapter 1 they provide a concise description of the historical and legal foundations of P.L. 99-457, Part H. Chapter 2 presents an annotated summary of the law and implementing regulations. In Chapters 3 and 4 the authors describe the 14 components required in a statewide, comprehensive early intervention system and illustrate how states are developing these systems. They provide numerous instruments and data collection strategies for documenting compliance with the 14 minimum components.

G.   Individuals with Disabilities Education Act (including the
     IDEA Amendments of 1991, P.L. 102-119). (Available from
     LRP Publications, 747 Dresher Rd., Suite 500, Horsham, PA
     19044-0980)

H.   National Information Center for Children and Youth with
     Disabilities. (1991). The education of children and youth
     with special needs: What do the laws say? News Digest, 1
     (1), 1-15.

          This publication presents a brief discussion of laws
          related to the educational and civil rights of children
          and youth with disabilities through the age of 21. A
          resource list of organizations and a bibliography of
          additional readings are provided for readers who want
          more specific information.

I.   Shonkoff, J. P., & Meisels, S. J. (1990). Early childhood
     intervention: The evolution of a concept. In S. J. Meisels
     & J. P. Shonkoff (Eds.), Handbook of early intervention.
     Cambridge: Cambridge University Press.

          Drs. Shonkoff and Meisels describe the evolution of
          early childhood intervention. They trace the theoretical
          and legislative history of the field. They analyze
          P.L. 99-457 and examine four broad issues that they
          believe will launch us into an exciting new era of early
          intervention in the 1990s.

J.   Smith, B. J. (1988). Early intervention public policy: Past,
     present, and future. In J. B. Jordan, J. J. Gallagher, P. L.
     Hutinger, & M. B. Karnes (Eds.), Early childhood special
     education: Birth to three. Reston, VA: ERIC Clearinghouse
     on Handicapped and Gifted Children.

          Dr. Smith discusses the evolution of public policies
          related to early intervention services. She reviews the
          past trends in federal and state policies that have
          provided funding and programming for very young
          children and their families. She describes the present
          status of federal and state policies for early
          intervention under P.L. 99-457 and proposes several

policy challenges that lie ahead for the field of early intervention.

K. Smith, B. J., & Strain, P. S. (1988). Early childhood education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8 (1), 37-47.

The authors propose several future challenges for the early childhood special education field. They suggest that in the next decade early childhood special education public policy developments will be related to implementing current policy under P.L. 99-457 and to expanding policy in order to assure that quality services are available to all eligible children and families.

L. Thiele, J. E., & Hamilton, J. L. (1991). Implementing the early childhood formula: Programs under P.L. 99-457. Journal of Early Intervention, 15, 5-12.

The authors describe the progress states and U.S. territories are making in implementing the Part H program and Section 619 preschool grants programs authorized by P.L. 99-457. They note some of the particular challenges states faced in the third year of the five year phase-in period for Part H and Section 619.

M. Trohanis, P. L. (1988). Preparing for change: The implementation of P.L. 99-457. In J. B. Jordan, J.J. Gallagher, P. L. Hutinger, & M. B. Karnes (Eds.), Early childhood special education: Birth to three. Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

Dr. Trohanis describes how the P.L. 99-457, Part H program represents new policy that must be translated into action by all states participating in this program. He outlines the process of change as it relates to Part H. He discusses the role of the change agent in ensuring that the targets of change (i.e., the users) are kept in mind throughout the change process.

N. Walsh, S., & McKenna, P. (1990). <u>Laws affecting children with special needs: Selected federal statutes and regulations</u>. Horsham, PA: LRP Publications.

This convenient loose-leaf reference contains the law and regulations that relate to the delivery of services to children with special need, birth through 21 years.

INSTRUCTIONAL MODULE II

Infants and Toddlers With Disabilities and Their Families:

Related Laws

PART TWO
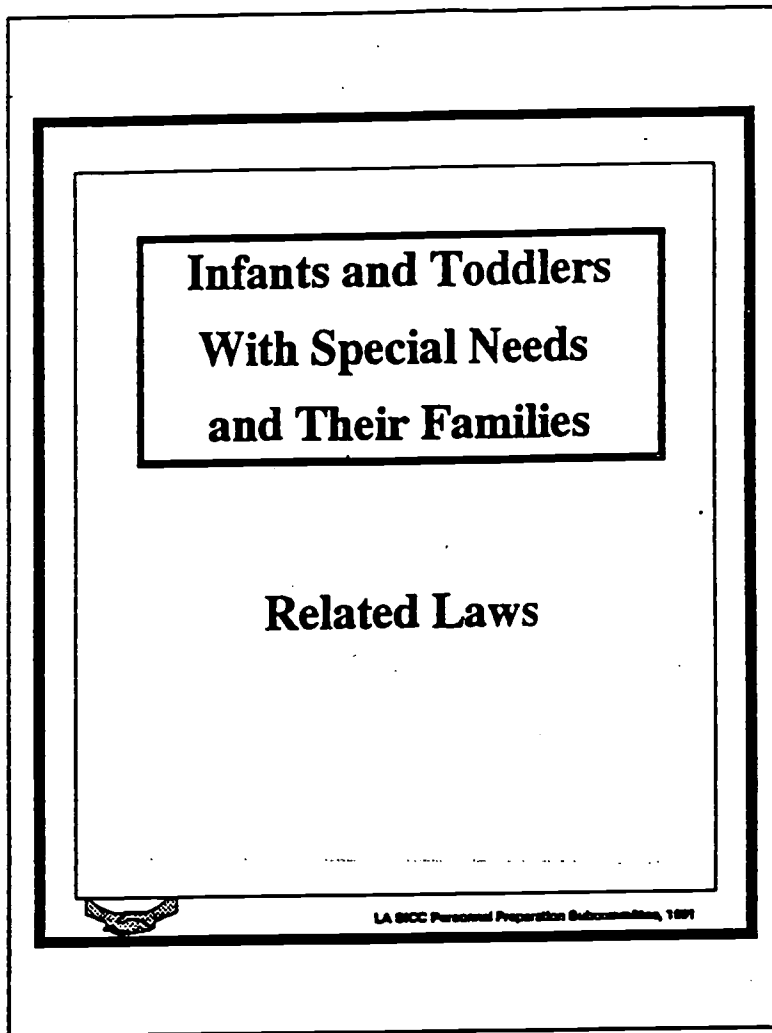
Supporting Materials

   I.   Lecture Notes
  II.   Student Handout for Note-Taking
 III. Additional Student Handouts
 IV. Transparency Samples

Faculty
Presentation
Guide

Infants and Toddlers With Special Needs and Their Families

Related Laws

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Law Transparency #1

Objectives

Participants will be able to:

✓ Describe the major federal legislation related to serving young children with disabilities and their families.

✓ Describe the major provisions of P.L. 99-457.

✓ Describe the major themes that underlie current legislation for young children with disabilities and their families.

✓ Identify major challenges and future directions in early intervention and service delivery.

Lecture Notes

**Faculty
Presentation
Guide**

Law Transparency #2

Major Federal Legislation
in Early Intervention

1965	Project Head Start
1967	EPSDT Program
1968	HCEEP Network
1972	Children With Disabilities in Head Start
1975	P.L. 94-142 (EHA)
1986	P.L. 99-457
1990	I.D.E.A. (P.L. 101-476)
1991	P.L. 102-119

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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**Faculty
Presentation
Guide**

Law Transparency #3

Project Head Start
(1965)

✔ Serves poverty children ages 3 - 5
  ● about 2/3 from minority groups
  ● 10% must have disability (currently about 13% have disabilities)
✔ Provides wide array of service
  ● Day care
  ● Education
  ● Medical/Dental
  ● Family Support

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Faculty Presentation Guide

Law Transparency #4

HCEEP
(1968)

✔ Intended to establish and demonstrate the feasibility of various models and programs

✔ More than 600 funded since 1968, 80% continuation rate

✔ Now called the Early Education for Handicapped Children Program

✔ Increasing emphasis on infants and toddlers

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Faculty Presentation Guide

Law Transparency # 5

EHA - Public Law 94-142
(1975)

✔ Free and appropriate public education for all children with disabilities

✔ Individualized planning required

✔ Least restrictive environment

✔ Procedural safeguards/due process

✔ Optional services for 3 - 5 year olds

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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**Faculty
Presentation
Guide**

Law Transparency # 6

Public Law 99-457

(1986)

✓ **Extended P.L. 94-142** to
children ages 3 - 5 years
- Five year timeline with required
implementation
- 1991 - All states have established
mandates

✓ **New Part H** regarding
Infants and Toddlers
- Voluntary for each state
- Incentives and guidelines
established

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

LA SICC Personnel Preparation Subcommittee, 1991

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Eligibility for Infant and Toddler Program

States may establish criteria for each of these three categories:

- ✔ **Established delay** (required)
- ✔ **Conditions likely to result in delay** (required)
- ✔ **At-risk** (optional)

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Law Transparency # 8

Components of the Individualized Family Service Plan (IFSP)

✔ Child's present level of development
✔ Family resources, priorities, and concerns
✔ Major outcomes, criteria, procedures, and timelines for the child and family
✔ Early intervention services to be provided
✔ Dates and duration of services
✔ Case manager or service coordinator
✔ Transition plan
✔ Statement of natural environments in which services will be provided

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Law Transparency # 9

A Coordinated System of Services

✔ Lead agency must be established
- Could be Education or another department
- Lead agency is responsible for ensuring services

✔ Interagency coordination is essential
- States must have a state ICC
- Many also have local ICCs

✔ Service coordination
- Designed to help families and children gain access to services

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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Law Transparency # 10

Public Awareness

✔ Child Find (screening and identification program) is needed.

✔ Public awareness activities must be provided.

✔ A central directory must be established describing services, resources, experts, and demonstration projects.

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Law Transparency # 11

Interdisciplinary Personnel

- ✔ **Personnel standards**
  - ● **Must be established across discipline**
  - ● **"Highest level" requirement**
- ✔ **Multiple Disciplines**

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Lecture Notes

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Law Transparency # 12

Major Themes Underlying Legislation

- ✔ Family-Centered

- ✔ Individualized

- ✔ Coordinated

- ✔ Normalized

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Law Transparency #13

Laws and
Services in

Lecture Notes

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Law Transparency # 14
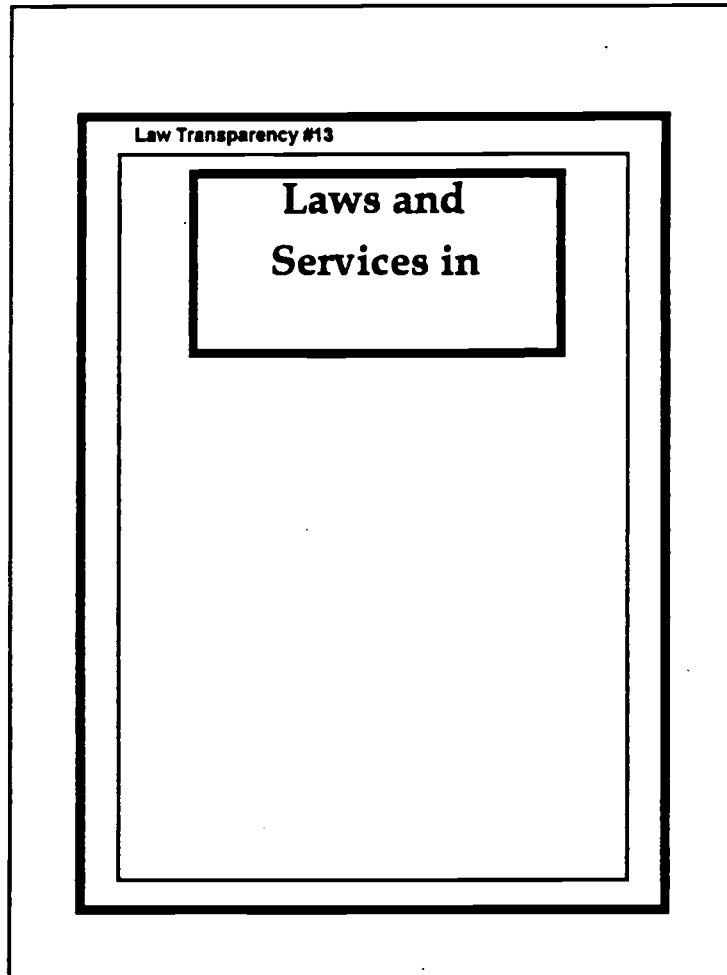
Future Themes/Directions

✔ **Rethinking traditional
discipline boundaries**

✔ **Redesigning service
delivery systems**

✔ **Training**

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Lecture Notes

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Infants and Toddlers
With Special Needs
and Their Families

Related Laws

Law Transparency #1

Objectives

Participants will be able to:

✓ Describe the major federal legislation
related to serving young children with
disabilities and their families.
✓ Describe the major provisions of
P.L. 99-457.
✓ Describe the major themes that underlie
current legislation for young children with
disabilities and their families.
✓ Identify major challenges and future
directions in early intervention and service
delivery.

Law Transparency #2

**Major Federal Legislation
in Early Intervention**

1965	Project Head Start
1967	EPSDT Program
1968	HCEEP Network
1972	Children With Disabilities in Head Start
1975	P.L. 94-142 (EHA)
1986	P.L. 99-457
1990	I.D.E.A. (P.L. 101-476)
1991	P.L. 102-119

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Project Head Start
(1965)

✓ Serves poverty children ages 3 - 5
   ● about 2/3 from minority groups
   ● 10% must have disability (currently about 13% have disabilities)
✓ Provides wide array of services
   ● Day care
   ● Education
   ● Medical/Dental
   ● Family Support

HCEEP
(1968)

✓ Intended to establish and demonstrate the feasibility of various models and programs

✓ More than 600 funded since 1968, 80% continuation rate

✓ Now called the Early Education for Handicapped Children Program

✓ Increasing emphasis on infants and toddlers

EHA - Public Law 94-142
(1975)

✓ Free and appropriate public education for all children with disabilities

✓ Individualized planning required

✓ Least restrictive environment

✓ Procedural safeguards/due process

✓ Optional services for 3 - 5 year olds

Law Transparency #6

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Law Transparency #7

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Law Transparency #8

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Law Transparency #9

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  ● Could be Education or another department
  ● Lead agency is responsible for ensuring services
✓ Interagency coordination is essential
  ● States must have a state ICC
  ● Many also have local ICCs
✓ Service coordination
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Law Transparency #11

✓ Personnel standards
  ● Must be established across discipline
  ● "Highest level" requirement
✓ Multiple Disciplines

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Law Transparency #13

Major Themes Underlying Legislation

- ✓ Family-Centered
- ✓ Individualized
- ✓ Coordinated
- ✓ Normalized

Law Transparency #14

Future Themes/Directions

- ✓ Rethinking traditional discipline boundaries
- ✓ Redesigning service delivery systems
- ✓ Training

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Public Law 99-457
Amendments to the Education
of the Handicapped Act

to authorize a new preschool program for three to five year olds and an early intervention program for handicapped infants and toddlers and for other purposes.

What does the New Law (P.L. 99-457) Cover?

The U.S. Congress has enacted legislation to expand coverage under the Education for All Handicapped Children Act (P.L. 94-142), to mandate a preschool program to serve children age three through five, to establish a new Early Intervention State Grant Program for infants and toddlers from birth through age two, and expand and improve various discretionary programs within the Education of the Handicapped Act (EHA) programs. President Reagan signed the bill into law on October 8, 1986.

The new law (P.L. 99-457) repeals the existing Pre-School Incentive Grant Program which in school year 1985-1986 reimbursed school systems with approximately $110 per child served between the ages of three and five years and replaces it with a Pre-School Grant Program.

When Must the Pre-School Provisions of P.L. 99-457 be Implemented?

States must guarantee in their P.L. 94-142 state plans that all children with handicaps from age three will be served by school year 1990-1991, with an additional year granted to the states to meet the three to five year mandate if the Congress fails to appropriate the necessary funds. Under any circumstance, all children with handicaps between the ages of three and five, inclusive, must be served by school year 1991-1992.

The one-year waiver would take effect if the Congress fails to appropriate 1) a total of $656 million during fiscal years 1987, 1988, and 1989 or 2) at least $306 million in fiscal year 1990.

Failure to serve all children three to five will result in the loss of: the state's funds under the Pre-School Grant; the ability to count the three to five year old children in the P.L. 94-142 child count along with the funding attached to that reimbursement formula; and, any discretionary grants under EHA specifically related to pre-school services.

What are the Provisions of the Law for Pre-School Children?

Pre-school services will generally be defined according to the requirements, rights, and protections under P.L. 94-142. In effect, a free, appropriate public education to all children with handicaps from age three must be guaranteed, including provision of Individual Education Programs (IEP), Least Restrictive Environment (LRE), due pro-

cess protections, appropriate parental involvement and other basic P.L. 94-142 provisions.

There are several provisions specific to three to five year olds. For instance, children with disabilities in this age group will not need to be labeled with a specific disability. Since family services play an important role in pre-school programming, instruction for parents, to the extent desired by the parents, is an appropriate provision within the child's IEP. Service delivery models can range from part day home-based to full day center-based, depending on the unique needs of a particular child. Finally, although the program is administered through state and local education agencies, they may contract with other public and private programs, agencies, and providers in order to provide the full range of services to comply with the law.

How will Funds be Provided to States for Pre-School Children?

In passing P.L. 99-457, the Congress is promising a substantial increase in federal funding for pre-school services. The new funding system to be used for the first three years of the Act is established on two tracks. For all preschoolers presently served, the law authorizes up to $300 per child in FY 1987 (school year 1986-87), up to $400 per child in FY 1988 and up to $500 per child in FY 1989. During this same three-year period, all new pre-schoolers served each year (the total number served minus those served in the previous year) will be funded at up to $3,800 per child for one year. During this three year phase-in, an estimated 80,000 presently unserved children are expected to receive services under the Pre-School Grant. States can decide how many new children to serve in any of the phase-in years, with the understanding that all children must be served by school year 1990-1991. The $3,800 per child reimbursement is based on an estimation that approximately 27,000 additional children will be served during each of the three phase-in years. If states were to serve more than that amount in a given year, the $3,800 per child reimbursement would be proportionally reduced. Following the three-year phase-in period, all three to five year old children served will generate up to $1,000.

It is important to note that all of the above funding projections are based on authorization levels in the law. The Congress must decide each year exactly what amount it will appropriate. Again, regardless of the amounts appropriated, the full mandate is applicable starting school year 1991-1992.

Also important to note is that the Pre-School Grant and the P.L. 94-142 State Grant are forward funded (i.e., funds appropriated for FY 1987 are made available on July 1, 1987 for use in school year 1988-89).

During fiscal year 1987, the State Education Agency (SEA) must pass on to Local Education Agencies (LEA) and Intermediate Education Units (IEU) at least 70 percent of the Pre-School Grant funds. In fiscal year 1988 and in subse-

quent years, the state must pass on at least 75 percent of the funds to LEAs and IEUs. The state may not expend more an five percent of the funds for administration in any iiscal year.

The new law also contains provisions requiring state policies and procedures for the development and implementation of interagency agreements between the SEA and appropriate state and local agencies defining financial responsibilities for providing education and for resolving disputes.

The Act also prohibits federal and state funds, particularly those currently allocated for the Title V Maternal and Child Health Block Grant and Title XIX Medicaid programs from being reduced in serving pre-school children.

What are the Early Intervention Requirements for States?

P.L. 99-457 establishes a new Early Intervention State Grant program to serve infants and toddlers from birth through the age of two. The program becomes Part H of the Education of the Handicapped Act.

Once a state applies for, qualifies for, and receives funds under Part H, it must assure the Federal Government that it will have in place a statewide, comprehensive, coordinated, multi-disciplinary, interagency system to provide early intervention services for all infants and toddlers with ndicaps and their families within four years of the receipt of such funds.

What are the Timelines for Establishing the Early Intervention Program?

During the first two years from the date the Early Intervention Program receives funds, the state must assure that it is planning, developing, or implementing the statewide system. To obtain funds in the third and fourth years, the state must assure that it has adopted a policy incorporating the components of a statewide system and that the system will be in place by the beginning of the fourth year. During this time period, the state need only conduct multi-disciplinary assessments, develop the IFSPs, and make case management services available.

During the fifth and succeeding years, the statewide system must be fully operational and all eligible infants and toddlers must be served. Any state that already has a P.L. 94-142 mandate in effect from birth will automatically be eligible for funding under the Early Intervention Program.

Who is Eligible for Early Intervention Services?

"Handicapped infants and toddlers" is defined to mean individuals from birth to age two, inclusive, who need early intervention because they are: 1) experiencing developmental delays in one or more of the following areas: cognitive development, psycho-social development, or self-help skills; or 2) have a diagnosed physical or mental ition which has a high probability of resulting in developmental delay. States also have the option of serving infants and toddlers who are "at risk" of having substantial

States may also serve children after their third birthday up until such time as the child begins being served under P.L. 94-142. Transition and coordination between the Early Intervention Program and the special education system is required.

What is Included in Early Intervention Services?

Services under this program must be designed to meet the developmental needs of the child in one or more of the following areas: physical development, cognitive development, language and speech development, psychosocial development or self-help skills. Such services include:
- family training, counseling and home visits;
- special instruction;
- speech pathology and audiology;
- occupational therapy;
- physical therapy;
- psychological services;
- case management;
- medical services only for diagnosis or evaluation;
- early identification, screening, and assessment; and
- health services necessary to assist the child to benefit from other early intervention services.

The services must meet state standards and be provided by qualified personnel at no cost except where Federal or state law provides for a system of payments by families, including sliding fees. The services must also be provided in accordance with an individualized family service plan (IFSP).

How is an IFSP Developed?

Each child and its family must receive a multi-disciplinary assessment of their unique needs and the identification of services appropriate to meet those needs specified in a written IFSP. The IFSP must be developed within a reasonable period of time after the assessment. Parents may bring a helper to the IFSP meeting to assist them in presenting their views.

Once developed, the IFSP must be evaluated at least annually, and the family must be provided a review of the plan at least every six months. Specific components of an IFSP include:
- a statement of the child's present level of development;
- a statement of the family's strengths and needs as they relate to assisting the child;
- a statement of the anticipated major outcomes to be achieved and how progress is to be measured;
- identification of the specific early intervention services to be delivered, including the frequency, intensity, and method of delivery;
- identification of the case manager for implementation of the plan and coordination with other agencies; and
- transition steps to special education services under P.L. 94-142.

What are the Components of a State Early Intervention System?

The new law specifies the minimum components of a statewide, comprehensive, coordinated, multi-

- definition of "developmentally delayed";
- timetable to provide services within four years;
- a provision for timely evaluations and needs assessment; individualized family services plans, including case management;
- a comprehensive child find and referral system;
- a public awareness program;
- a central directory of services and resources;
- a comprehensive system of personnel development;
- a single line of authority to administer, supervise, and monitor the program;
- a contracting process or other arrangements with local service providers;
- a reimbursement system;
- personnel standards; and
- a data collection process.

The state plan containing this information must be developed with participation from the public, including public hearings. A summary of the public comments and the state's response must be included in the plan. Assurances of equitable distribution of resources among all geographical areas within each state is also required.

What State Agency is Responsible for the Early Intervention Program?

P.L. 99-457 gives the Governor full discretion to designate a single lead agency to carry out the Early Intervention Program. The lead agency may be the state education agency, another state agency involved with providing ser-.ces to children or a State Interagency Coordinating Council. The lead agency is responsible for:
- the general administration, supervision, and monitoring of programs and activities;
- the identification and coordination of all available Federal, state, local and private resources, and the assignment of financial responsibility to appropriate state agencies;
- the entering into formal state interagency agreements that offer such financial responsibility; and
- the resolution of disputes.

What is the Role of the State Interagency Coordinating Council?

The Act requires a State Interagency Coordinating Council which may serve as the lead state agency. The Council, appointed by the Governor, shall have 15 members, of which at least three are parents of infants or toddlers with handicaps age three through six; at least three are public or private providers of services; at least one represents the state legislature; at least one is involved in personnel preparation, and others representing each of the state agencies involved in paying for or providing early intervention services. The Council's main functions are to advise and assist the lead state agency in preparing the Early Intervention application, in the identification of fiscal and other support, in the assignment of financial responsibility to appropriate agencies, and in the promotion of the interagency agreements. Council meetings must be held at least quarterly, be open and accessible to the public. Funds under the Early Childhood Program may be used to staff and carry out the

functions of the Council.

What Funding is Authorized for the Early Intervention Program?

The new law authorizes $50 million in FY 1987, $75 million in FY 1988, and "such sums as may be necessary" for the next three years. The Congress must appropriate the actual amounts on an annual basis. Eligible states will be allotted their share of the funds based on a census count of their zero to two population in relation to the two populations of other states. No state will receive less than one-half of one percent of the appropriated amount. For example, if $50 million is appropriated in FY 1987, the minimum allocation states would receive is $250,000. Since there are already significant amounts of federal and other funding sources already providing services to infants, the Act requires that the Early Intervention funds be used as the "payer of last resort." States are not allowed to reduce medical or other assistance from other sources, including specifically Title V Maternal and Child Health and Title XIX Medicaid funds.

In addition to using funds to plan, develop, and implement the statewide system, state agencies may also use the funds for direct services not provided by other sources and to expand and improve existing services.

What Procedural Safeguards are Mandated by the Law?

States are required to develop a system of procedural safeguards that, at a minimum, must provide for:
- the timely resolution of administrative complaints by parents and the right to appeal to a state or Federal court;
- confidentiality of personal, identifiable information;
- the opportunity to examine records;
- procedures to protect the child if parents or guardians are not known, unavailable, or the child is a ward of the state; and
- the provision of services pending resolution of the complaint.

Two types of complaints by parents are allowable. One concerns the state's compliance with the law (e.g., failure to develop an IFSP) while the other deals with more systemic issues, such as the state's failure to develop a statewide system. The first type of complaint must be presented to an impartial individual and be speedily resolved.

Now that P.L. 99-457 has been Passed, what will Happen Next?

Work has already begun by the Federal Office of Special Education Programs to develop rules and regulations to specify how the provisions of the law will be implemented. This is a process in which the government will propose these regulations for critical review by those who will be responsible in the nation's SEAs and LEAs for implementation of P.L. 99-457. Others who will react include ARCs and other advocacy and professional organizations as well as individuals who have interest.

What Specifically Should ARCs and Other Advocates be Planning to do?

With regard to the three to five pre-school mandate, since all states are already providing some level of services to at least a portion of their pre-schoolers with handicaps and have also at least begun to plan, develop or implement Early Childhood Planning Grants under the previous EHA authority, most will now have to alter their planning to accommodate the new required timelines under P.L. 99-457.

Because the states will begin modifying their special education state plans in the near future to qualify for the new funds which will become available, ARC chapters should determine their state's current status regarding their present Early Childhood Planning Grant. In those few states that are serving all of its three to five population, it is essential to determine whether those programs fully comply with P.L. 94-142 standards (e.g., IEP, LRE, due process, etc.). If not, the state, under P.L. 99-457, must begin to fully meet those standards. If the state is meeting P.L. 94-142 standards, a determination of how the state intends to use the additional funds to expand and improve services should be made. It is important to remember that states cannot supplant any existing funds currently being used for pre-school services. New funds should finance additional or expanded services, for example, transportation or extended school year programs.

In those states in the planning and/or development stage, it is vital that work occur with the state and local providers on a variety of activities including:
finding unserved children;
* estimating the number of new children to be served during the phase-in period;
* assessing personnel shortages and needs;
* assisting new parents in understanding their rights and responsibilities under P.L. 94-142;

* monitoring the development of interagency agreements; and
* providing comments during the development of sta.. plans.

Because the early intervention mandate will only ap 'y to those states who successfully apply for funds, the fi t and probably most important role for the ARC to play in obtaining a statewide Early Intervention System is to convince the Governor and the state legislature to submit 1 application. Given the relatively small amount of fun s authorized in the program, some states will be reluctant to apply. ARCs should stress the cost effectiveness of ear'y intervention on later special education and long-term ca : for persons with handicaps.

In regards to the specific provisions of the Early Intervention program, several key provisions requiring a . tive ARC involvement include:
* Which state agency is best suited to be the lead agency?
* How should "developmentally delayed" and "at risk" be defined?
* How will the state identify all the children?
* Should "at risk" children be served?
* Who should be appointed to the Coordinating Counc""
* What is the best utilization of the program's funds?
* How can meaningful interagency agreements be reached and fully implemented?
* How can "new" parents be helped to participate in th IFSP?
* How should the children reaching three years of age be successfully transitioned in special education?
* How can advocates make sure funds are not being supplanted?

Objectives

Participants will be able to:

✓ Describe the major federal legislation related to serving young children with disabilities and their families.

✓ Describe the major provisions of P.L. 99-457.

✓ Describe the major themes that underlie current legislation for young children with disabilities and their families.

✓ Identify major challenges and future directions in early intervention and service delivery.

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- **about 2/3 from minority groups**
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- **Family Support**

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✔ **Increasing emphasis on infants and toddlers**

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✔ **Lead agency must be established**
  ● **Could be Education or another department**
  ● **Lead agency is responsible for ensuring services**
✔ **Interagency coordination is essential**
  ● **States must have a state ICC**
  ● **Many also have local ICCs**
✔ **Service coordination**
  ● **Designed to help families and children gain access to services**

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Interdisciplinary Personnel

✔ **Personnel standards**

- **Must be established across discipline**

- **"Highest level" requirement**

✔ **Multiple Disciplines**

Major Themes Underlying Legislation

✔ **Family-Centered**

✔ **Individualized**

✔ **Coordinated**

✔ **Normalized**

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Laws and

Services in

Future Themes/Directions

✓ **Rethinking traditional discipline boundaries**

✓ **Redesigning service delivery systems**

✓ **Training**

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Family Centered Practices: An Introduction

Infants and Toddlers With Special Needs and Their Families

The Importance of the Family

INSTRUCTIONAL MODULE I

Infants and Toddlers With Disabilities and Their Families:

The Importance of the Family

PART ONE

I.   Objectives
II. Outline
III. Explanatory Materials
IV. Evaluation
V.   Resource Material

II.   Outline of Session

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Instructional Module I

Infants and Toddlers with Disabilities and Their Families: The Importance of the Family

I. **Objectives**

At the completion of this module, the student will:

A. Provide a functional definition of the family.

B. Identify factors that affect family functioning.

C. Identify trends in professional conceptualizations of families and of professional/family relationships.

D. Discuss the rationale for, and issues in, family-centered intervention approaches.

E. Describe the key elements of an ecological model of human development and of family systems theory.

   [Transparency 1]

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      3.   Principles for Intervention

III. Explanatory Material/Expansion of Module Outline

The most effective introduction to family-focused or family-centered intervention comes from dialogue between students and families themselves. Consequently, it is strongly recommended that this module be co-taught by family members and professionals. Instructors should bring to their classrooms members of families that contain a young child with a disability who are the consumers of professional services that students are being trained to provide. Such family members should represent diversity to include mothers, fathers, and siblings. It will probably be sufficient that instructors simply suggest to family members that they talk informally to the class about what, from a consumer's perspective, would be important for students to know or understand to be effective with families. Instructors may wish to review key elements in the module outline to guide information sharing with families about personal experiences during the discussion.

Instructors may want to consider a preliminary dialogue with students about family functions and factors that affect family functioning. It is very likely that students will be able to generate a reasonably comprehensive list. Some interesting differences in perspectives might emerge from discussions revolving around structural versus functional definitions of families. The instructor will want to consider introducing specific concepts such as informal and formal social support or the interaction of multiple risk factors. If such a class discussion precedes the class dialogue with family members, students can be alerted to listen for mention of sources of support, important family values, etc.

One can argue, alternatively, that an initial conceptual discussion might serve to distance students from the family's experience (as, some would suggest, professional training tends to do in general). An instructor who leans toward this point of view might wish to record the family-members-presentation and dialogue with students. As subsequent class discussion addresses the points raised in the outline above, the tape will be available to supplement students' recollection of what the family member has said in relation to specific issues. If the instructor chooses to use a follow-up discussion, he or she should emphasize that intervention can be professionally-centered or family-centered. The traditional professionally-centered approach is characterized by professionals making decisions for and implementing interventions with families. Family-centered approaches are supported

by the realization that the young child with disabilities is best understood within the family context. Central to this approach is the fact that changes in any one family member affects every other member. For example, a young child that learns effective social-communication skills will favorably affect parents, resulting in more numerous and prolonged playful interactions. Such interactions provide additional opportunities for the child to further improve social-communication behaviors. Family-center approaches are often referred to as a systems-ecological or transactional philosophy.

The instructor should also emphasize that there is great family diversity within our society. Such diversity is characterized by rather dramatic changes in what American families look like along a number of dimensions. For example, there has been a dramatic increase in single parent families. Another example of change is the great diversity in cultural backgrounds now represented by families that constitute our society. Such changes should be viewed positively and students should be helped to understand that to be effective professionals must learn to collaborate with families in ways that encourage and respect their abilities and rights to make decisions about specific outcomes and services for their child with a disability and for their family.

Finally, instructors should explain that families, like individuals, are characterized by their uniqueness. Professionals cannot assume that all families will react in similar ways to the presence of a child with a disability. Different families bring different strengths, resources, concerns, and values to the professional-family relationship. Evidence does suggest, however, that most families are very resourceful and are able to meet the generic and special challenges of parenting a child who happens to have a disability.

Inviting family members to co-teach this module not only provides an opportunity for live dialogue between family members and students but also demonstrates the instructor's own commitment to creating a parent/professional partnership. If one believes that students learn from what they see, not from what they are told, the effort is clearly worth making. However, if it is impossible to bring family members into the classroom or to move the class to a service setting where family members could speak with the students, the instructor may substitute the video, Supporting Families and Their Prematurely Born

Babies, Beyond Assumptions When Parents Talk and Providers Listen. If no video monitor is available, the essays by Fern Kupfer and Ann Oster (National Center for Clinical Infant Programs, 1985) might be used as a starting point for discussion.

A. Functional Definition of Family [*Transparency 2*]

There are many ways to define "family." One definition is "A group of people, related by blood or circumstance, who rely upon one another for security, sustenance, support, socialization and stimulation" (Chynoweth & Dyer, 1991). Another way to think about families is in terms of the functions they perform for individual members and for society in general. Families provide security, both physical and psychological, for their members. Families also provide sustenance or monetary support to help meet the basic requirements to support life such as food and clothing. Families provide emotional support for its members by providing physical attention, affection, and acceptance. Families also provide stimulation for its members which promotes growth and learning throughout the lifespan. Finally, families also serve as mediators between its members and society, resulting in the transmission of values and culture.

B. Factors That Affect Family Functioning [*Transparency 3*]

There are many factors that can affect family functioning, making each family very unique in the way it functions. Some of these factors include structure, stages, support, resources, and values.

1. Structure [*Transparency 4*]

One important variable that influences overall functioning is family structure. "Who is in the family" and "what roles do they play" very much influence day to day family life. Families in our society have changed tremendously during the past few years. No longer is the "typical" family characterized by intact couples with children with mothers playing exclusively expressive roles like child caregiving and fathers playing exclusively instrumental roles like providing income. There has been a dramatic increase in the number of single parent families. There also have been profound changes in the traditional "roles" held by family members as more mothers have found it necessary to engage in out of home employment. This does not mean,

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however, that contemporary families are less able to function effectively. It does mean that families have changed in response to changing demands and circumstances in general society.

2. Stages [*Transparency 4*]

Another important consideration in family functioning is the family life cycle stage. Traditionally, family life cycle stage has been identified by the chronological age of the youngest child. This concept is important since the needs, priorities, and concerns of families are partly determined by the task demands of each stage. For example, the family tasks associated with adapting to the presence of an infant will no doubt be different than those tasks associated at a later point in the family life cycle when all children have departed from the household.

3. Support [*Transparency 4*]

Social support refers to the resources such as information provided to families in response to the need for aid and assistance. The persons and institutions with which a family and its members come into contact, either directly or indirectly, are referred to as the family's personal support network. There is a distinction between two sources of support. Informal support networks include individuals such as friends, neighbors, and extended family members and institutions such as a church that are accessible to provide support the families on a daily basis. Formal support networks include both professionals (e.g., physicians and educators) and social agencies (e.g., hospitals and early intervention programs) that are formally organized to provide aid and assistance to families and individuals seeking help. Obviously, the quantity and quality of a family's social support network will influence a family's reactions to normative and non-normative events.

4. Resources [*Transparency 5*]

All families have resources. Resources may involve tangible things like money, housing, clothing or more intangible things like commitment to each other or a general philosophy that "things always work out". The influence of resources on overall family functioning is much more related to a family's perception of the adequacy of their resources than to the mere number or monetary value of resources.

5.   Values [*Transparency 5*]

Each family have its own value system. These values directly influence what individual family members view as concerns, needs, or priorities. Recent years has seen a dramatic increase in the number of different cultures represented by families that make up our society. Therefore, it is predictable that families will hold and express different values. It is important to recognize this fact and to be sensitive to and respectful of the influence that values and culture exert on individual and family behavior.

6.   Risk Factors [*Transparency 5*]

Research and experience have indicated that some individuals and families may be more at risk for problems than others. Several factors related to families, individual family members, and to society in general may singularly or in combination result in families experiencing difficulties. For example, a family composed of a teenaged mother and a premature infant residing in a rural area may be at risk because of the interaction of factors both internal to and external to the family. The teenaged mother may experience difficulty in providing resources for her infant, influencing such factors as the baby's nutrition and overall health status. The infant may be less responsive to the mother than would be a full-term baby, resulting in disturbances in mother-infant interactions. There may be a lack of formal support systems such as an early intervention program in a rural area, resulting in the lack of information or support. These factors could interact to put this family at risk for such factors as extreme stress experienced by the mother or the infant experiencing long-term developmental delay.

C.   Professional Conceptualizations of Families and Professional/Family Relationships

Early intervention, as a distinct field, is approximately 25 years old. During this brief history, professionals have viewed and involved families in different ways [*Transparency 6*]. It is important to note that families should have opportunities to exercise options about what roles they play during the intervention process. The important distinction of a family-centered approach from a professional-centered approach is that parents do have choices about what roles, if any, they play in the intervention programs and that professionals respect and support such

choices. One role that families can play is that of being a passive observer of professionals. This role has often been assigned parents by professionals for a number of reasons. Professionals may view families in negative ways. At the extreme families may be viewed as actually "causing" many of their child's problems by having poorly developed parenting skills. Another role families can play is that of being receiver of information from professionals. That is, professionals control the intervention process and inform parents of their decisions. One popular role for families is to carry out professionally-prescribed interventions. This role often involves parents and siblings as teachers of their child with a disability. Finally, families can be collaborators and decision-makers. Such a role means that family members have equal status with professionals and actually make final decisions about the intervention process. In the final analysis families should <u>always</u> choose the role(s) they wish to take.

D. Basic Elements of Ecological/Family Systems Theory

The current approach to understanding families and how they function usually involves the application of principles from two interrelated theories, the ecology of human development and family systems theory.

1. Ecological model of human development
[*Transparency 7*]

This view of human development envisions individuals as being embedded within a number of important systems. The interactions, both direct and indirect, between the individual and these systems help explain important human outcomes such as learning and socialization. Another key concept of human ecology theory is that individuals are changed by interactions with systems and, in turn, change the systems. These reciprocal exchanges are crucial to understanding human growth and development. Four major systems are usually considered from this model. First, there are the interactions within immediate settings called **microsystems**. Examples of microsystems include the family or a day care center. Second, there are the interactions between microsystems referred to as **mesosystems**. An example of such linkages would be staff from an early intervention program visiting the home setting of an infant. Third, exosystems are those settings that have a bearing on the development of a child, but in

which the child does not play a direct role. An example of an exosystem would be the workplace of parents. Finally, meso- and exosystems are set within the broad system of a particular culture. These systems are called macrosystems and represent a shared belief about how things should be done as well as the institutions designed to represent those assumptions.

2. Family Systems Theory

Another important set of principles currently used to understand families has evolved from family systems theory. First, there is the concept of circular causality. This principle holds that changes in any one member of a family affects other family members and the family system as a whole. Second, there is the concept of nonsummativity which holds that the family system as a whole is more than just the sum of its individual members. Third, the concept of equifinity involves the notion that similar stimuli may lead to different outcomes and similar outcomes may result from different stimuli. Fourth, communication is viewed as all behavior being interpersonal messages that contain both factual and relationship information. Fifth, all families have rules which operate as norms and serve to organize family interactions. Sixth, the concept of homeostasis holds that families strive to maintain stability via family norms and feedback loops. Finally, the tenet of morphogenesis holds that families also require flexibility in order to adapt to internal and external change.

E. Family-Centered Approaches [*Transparency 8*]

Traditionally, early intervention services have been characterized as being professionally-centered and focused only on the child. That is, professionals looked at what the needs of the child were, usually in isolation from the family context, and decided what and where intervention services should be provided. Family input was minimized or ignored completely. It is now apparent, however, that in order to maximize the positive outcomes of early intervention professionals must view the needs of the child within the family context and encourage parents to be informed decision-makers. That is, families, if they so choose, make final decisions about what outcomes are targeted for intervention and what services are provided.

1. Functional Definition

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The term family-centered refers to a combination of beliefs and practices that define particular ways of working with families that are consumer driven and competency enhancing.

2.   Assumptions [Transparency 9]

There are a number of assumptions that characterize a family-centered approach. First, changing children will change other family members. If children become more competent then family members will view the child and respond to him or her in different ways. Second, providing information and teaching parenting skills can change families. For those families who request specific information and training, changes can be expected in the way they view themselves and the way in which they interact with their children. Third, personal counseling can change families. Some families will request formal counseling as a priority, resulting in changes based on their ability to communicate better or in the reduction of stress. Fourth, increasing parent empowerment can change families. Parent empowerment involves working with parents in ways that enhance their sense of competence and decision-making abilities. One important way this can be achieved is through professionals explicitly acknowledging that it is the family that really contains the crucial figures in a child's life. Finally, providing more support services can change families. The most positive changes in families come about when professionals provide support services requested and valued by family members themselves.

3.   Principles for Intervention

Specific principles underlying a family-centered approach to early intervention include the following: (1) states and programs should define "family" in a way that reflects the diversity of family patterns and structures; (2) respect for and acceptance of each family's own structure, roles, values, beliefs, and coping styles is a cornerstone of family-centered intervention; (3) intervention systems and strategies must honor the racial, ethnic, cultural, and socioeconomic diversity of families; (4) respect for family autonomy, independence, and decision making means that professionals re-examine their traditional roles and practices and develop new practices when necessary to promote mutual respect and partnerships; (5) professionals are seen as the agents and instruments of families, and intervene in ways that maximally promote family decision making, capabilities, and

competencies; and (6) intervention practices are almost entirely strength- and competency-based and the provision of resources and supports aim primarily to strengthen a family's capacity to build both informal and formal networks of resources to meet needs.

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IV. Evaluation

Instructors may wish to evaluate student outcomes using one or both of the following techniques.

1. Prior to introducing this module, have students list five things they believe to be true about most individuals with disabilities and their families. Ask several students to share their beliefs in a class discussion. Collect the written statements from students. Following the completion of this module, discuss with students how their beliefs have been changed or modified. Note changes that reflect a better understanding of a family-centered philosophy.

2. <u>Knowledge test</u>. Instructors may want to use the following test in a pre-post fashion or a post-test only approach. Ask students to respond to the following ten statements by placing a "+" by the statement if they believe it represents family-centered intervention or a "-" if they believe it represents professionally-centered intervention.

(-) _____ 1. Professionals should understand that there is one ideal type of family that contains both a mother and a father, enabling these families to function better than other types of families.

(-) _____ 2. Professionals who are properly trained make better decisions for families than can be made by family members themselves.

(+) _____ 3. Professionals must understand that any changes produced in young children with disabilities affect other family members.

(+) _____ 4. Professionals should interact with families in ways that clearly indicate their respect for cultural and diversity in families.

(+) _____ 5. Professionals need to understand that formal and informal family support systems affect family functioning and child outcomes.

(-) _____ 6. Professionals need to understand that parenting a child with a disability inevitably leads to a dysfunctional family.

(-) _____ 7. Professionals' views on the needs of young children with disabilities result in more functional interventions that those based on the views held by families.

(-) _____ 8. A professional tells a parent that he or she <u>must</u> spend 30 minutes each day doing physical therapy.

(+) _____ 9. Professionals need to understand that families respond and adapt in different ways to stressors associated with parenting a child with a disability.

(+) _____ 10. Professionals and families should share information and collaborate on family and child outcomes but final decision-making should rest with the family.

V. Resource Materials

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INSTRUCTIONAL MODULE I

Infants and Toddlers With Disabilities and Their Families:
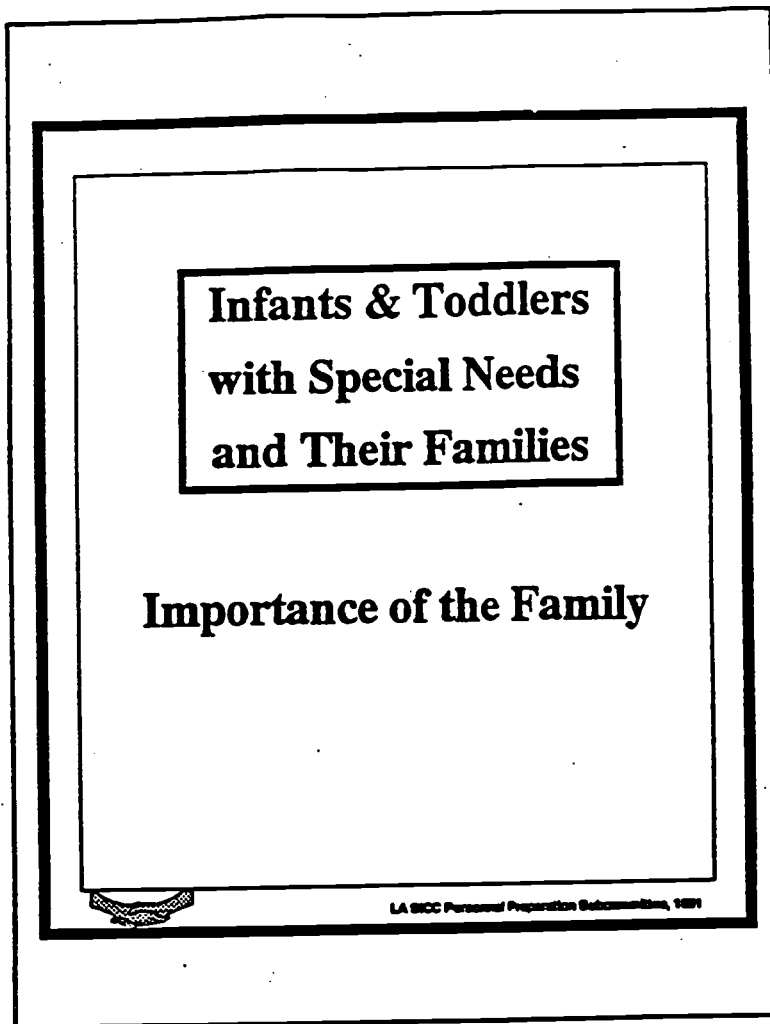
The Importance of the Family

PART TWO

Supporting Materials

  I.   Lecture Notes
  II.   Student Handout for Note-Taking
  III. Additional Student Handouts
  IV. Transparency Samples

Faculty Presentation Guide

Infants & Toddlers with Special Needs and Their Families

Importance of the Family

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Faculty Presentation Guide

Family Transparency # 1

Objectives

✓ Provide a functional definition of the family

✓ Identify factors that affect family functioning

✓ Identify trends in professional conceptualizations of families and of professional/family relationships

✓ Discuss the rationale for, and issues in, family-centered intervention approaches

✓ Describe the key elements of an ecological model of human development and of family systems theory

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Faculty
Presentation
Guide

Family Transparency # 2

A <u>family</u> is a group of
people, related by
blood or circumstance,
who rely upon one
another for security,
sustenance, support,
socialization, and
stimulation.

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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LA SICC Personnel Preparation Subcommittee, 1991

Faculty Presentation Guide

Family Transparency # 3

Some factors that affect family functioning:

- ✓ Structure
- ✓ Stages
- ✓ Support
- ✓ Resources
- ✓ Values
- ✓ Risk Factors

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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LA SICC Personnel Preparation Subcommittee, 1991

Faculty Presentation Guide

Family Transparency # 4

Family Functioning Factors

✓ **Structure**

Who is in the family?

What roles do they play?

✓ **Stages**

Child stage

Family stage

✓ **Support**

Informal support system

Formal support system

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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LA SICC Personnel Preparation Subcommittee, 1991

Family Transparency # 5

✓ **Resources**

   Adequacy of resources

✓ **Values**

   Family values,
   concerns, priorities,
   and perceptions

✓ **Risk Factors**

   Singular
   Interactive

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Family Transparency # 6
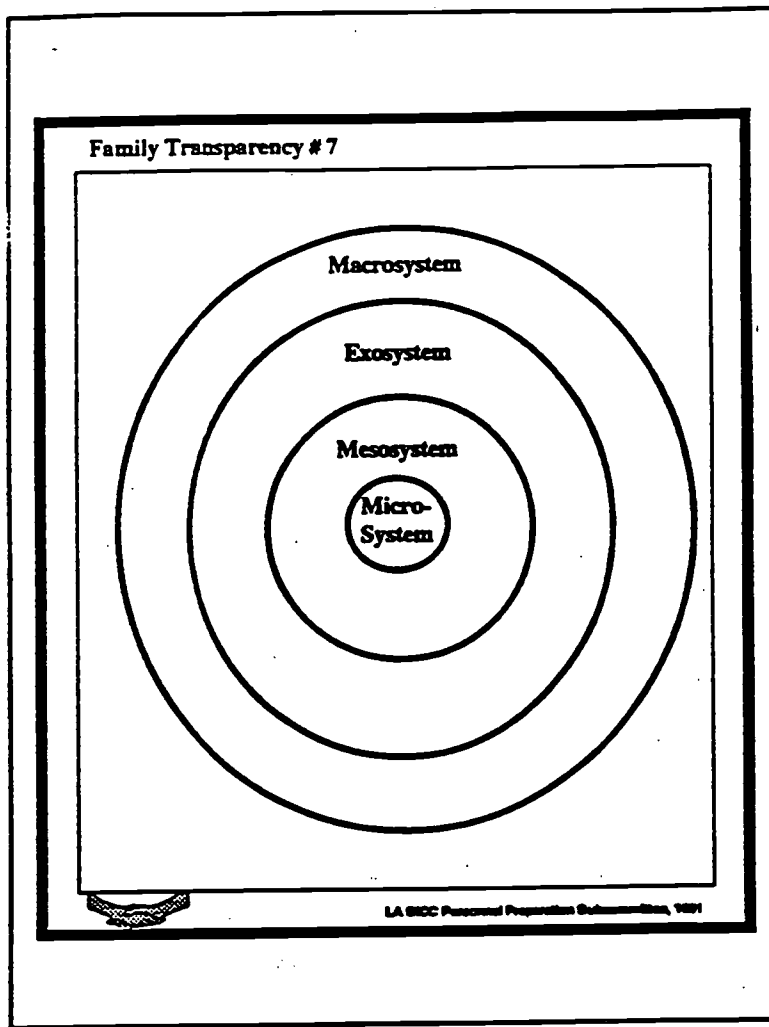
Options for Family Roles in Early Intervention

✔ Passive observer of professionals

✔ Receiver of information from professionals

✔ Carrying out professionally-prescribed interventions (parents as teachers)

✔✔ **Collaborators and decision-makers**

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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**Faculty
Presentation
Guide**

Family Transparency # 7

Macrosystem

Exosystem

Mesosystem

Micro-
System

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Lecture Notes

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Faculty Presentation Guide

Family Transparency # 8

<u>Family-centered</u> refers to a combination of beliefs and practices that define particular ways of working with families that are consumer driven and competency enhancing.

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

LA SICC Personnel Preparation Subcommittee, 1991

Family Transparency #9

Assumptions

✔ Changing children will change
other family members

✔ Providing information and
teaching parenting skills can
change families

✔ Personal counseling can change
families

✔ Increasing parent empowerment
can change families

✔ Providing more support can
change families

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

SICC Personnel Preparation Subcommittee, 1991

Infants & Toddlers
with Special Needs
and Their Families

Importance of the Family

Objectives

✓ Provide a functional definition of the family

✓ Identify factors that affect family functioning

✓ Identify trends in professional conceptualizations of families and of professional-family relationships

✓ Discuss the rationale for, and issues in, family-centered intervention approaches

✓ Describe the key elements of an ecological model of human development and of family systems theory

---

A **family** is a group of people, related by blood or circumstance, who rely upon one another for security, sustenance, support, socialization, and stimulation.

Some factors that affect
family functioning:

✓ Structure

✓ Stages

✓ Support

✓ Resources

✓ Values

✓ Risk Factors

**Family Functioning
Factors**

✓ Structure

  Who is in the family?

  What roles do they play?

✓ Stages

  Child stage

  Family stage

✓ Support

  Informal support system

  Formal support system

✓ Resources

  Adequacy of resources

✓ Values

  Family values,
  concerns, priorities,
  and perceptions

✓ Risk Factors

  Singular

  Interactive

Family Transparency #4

Options for Family Roles in Early Intervention

✓ Passive observer of professionals

✓ Receiver of information from professionals

✓ Carrying out professionally-prescribed interventions (serven as teachers)

✓✓ **Collaborators and decision-makers**

Family Transparency #7

Family Transparency #6

Family-centered refers to a combination of beliefs and practices that define particular ways of working with families that are consumer driven and competency enhancing.

Family Transparency #9

Assumptions

✔ Changing children will change other family members

✔ Providing information and teaching parenting skills can change families

✔ Personal counseling can change families

✔ Increasing parent empowerment can change families

✔ Providing more support can change families

OBJECTIVES

By the end of this module, the participant will be able to:

A. Describe types of natural environments in which early intervention services could occur.

B. Provide a rationale for the delivery of early intervention services in natural group environments.

C. Describe service delivery parameters for providing early intervention in the home.

D. List examples of interventions that could occur within a family's home and natural group environments.

E. Describe naturalistic teaching strategies to use when embedding a child's developmental goals into activities and routines within natural group environments.

F. Define the term natural environments as contained in Part H of the Individuals with Disabilities Education Act (IDEA).

OUTLINE

This module is organized as a one-hour session designed to provide participants with an overview of the importance of early intervention within natural environments. Professionals need to understand the impact that the learning environment has on both the child and the family. This module will define the term natural environment, describe the types of services that can be successfully delivered in natural environments, and describe the techniques for designing interventions in natural environments.

I. Natural Environments

  A. Types of natural environments

  B. Individual determination of natural environments

Objectives

✓ Provide a functional definition of the family

✓ Identify factors that affect family functioning

✓ Identify trends in professional conceptualizations of families and of professional/family relationships

✓ Discuss the rationale for, and issues in, family-centered intervention approaches

✓ Describe the key elements of an ecological model of human development and of family systems theory

LA SICC Personnel Preparation Subcommittee, 1991

A <u>family</u> is a group of people, related by blood or circumstance, who rely upon one another for security, sustenance, support, socialization, and stimulation.

Some factors that affect family functioning:

✓ **Structure**

✓ **Stages**

✓ **Support**

✓ **Resources**

✓ **Values**

✓ **Risk Factors**

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Family Functioning Factors

✓ **Structure**

Who is in the family?

What roles do they play?

✓ **Stages**

Child stage

Family stage

✓ **Support**

Informal support system

Formal support system

LA SICC Personnel Preparation Subcommittee, 1991

Family Transparency # 5

✓ **Resources**
   Adequacy of resources

✓ **Values**
   Family values,
   concerns, priorities,
   and perceptions

✓ **Risk Factors**
   Singular
   Interactive

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Options for Family Roles in Early Intervention

✔ Passive observer of professionals

✔ Receiver of information from professionals

✔ Carrying out professionally-prescribed interventions (parents as teachers)

✔✔ **Collaborators and decision-makers**

LA SICC Personnel Preparation Subcommittee, 1991

Family Transparency # 7

Macrosystem

Exosystem

Mesosystem

Micro-System

Family-centered refers to a combination of beliefs and practices that define particular ways of working with families that are consumer driven and competency enhancing

Assumptions

✔ **Changing children will change other family members**

✔ **Providing information and teaching parenting skills can change families**

✔ **Personal counseling can change families**

✔ **Increasing parent empowerment can change families**

✔ **Providing more support can change families**

By the end of this module, the participant will be able to:

- List and define the nine principles of family-centered care

- Describe one activity or strategy that characterizes each of the nine family-centered principles

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Family-Centered Principles

- Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate

- Facilitating family/professional collaboration at all levels of service provision: services for an individual child; program development, implementation, and evaluation; and policy formation

- Honoring the racial, ethnic, cultural, and socioeconomic diversity of families

- Recognizing family strengths and individuality and respecting different methods of coping

- Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information

- Encouraging and facilitating family- to-family support and networking

- Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into service delivery systems

- Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families

- Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs

Note. From *Overview of family-centered service coordination*, by L. Edelman, S. S. Elsayed, & M. McGonigel, 1992, St. Paul, MN: Pathfinder Resources, Inc.

Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate

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Facilitating family/ professional collaboration at all levels of service provision:

- services for an individual child

- program development, implementation, and evaluation

- policy formation

Honoring the racial, ethnic, cultural, and socioeconomic diversity of families

Recognizing family strengths and individuality and respecting different methods of coping

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Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information

Encouraging and facilitating family-to-family support and networking

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Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into service delivery systems

Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families

Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs

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Infants and Toddlers with Special Needs and Their Families

FAMILY-CENTERED PRACTICES:
An Introduction

Contents

OBJECTIVES

By the end of this module, the participant will be able to:

A.   List and define the nine principles of family-centered care.

B.   Describe one activity or strategy that characterizes each of the nine family-centered principles.

OUTLINE

This module is organized as an hour-long session designed to provide participants with an overview of family-centered principles. The information in this module expands upon the concept of family-centered approaches that was introduced in the module entitled *The Importance of Family* (Louisiana State Interagency Coordinating Council, Personnel Preparation Committee, 1991). Nine family-centered principles are outlined in this module. An additional nine modules provide material for hour-long sessions on each of the principles. Use of these additional modules allows instructors to provide participants with greater knowledge of and experience with the practices that typify each of the nine principles.

I.   Introduction to Family-Centered Practices

II.   An Overview of the Nine Family-Centered Principles

   A.   Recognizing that the family is the constant in the child's life while the service systems and personnel within those systems fluctuate.

   B.   Facilitating family/professional collaboration at all levels of service provision:

   ■   services for an individual child;

   ■   program development, implementation, and evaluation; and

   ■   policy formation.

C.   Honoring the racial, ethnic, cultural, and socioeconomic diversity of families.

D.   Recognizing family strengths and individuality and respect for different methods of coping.

E.   Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information.

F.   Encouraging and facilitating family-to-family support and networking.

G.   Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into service delivery systems.

H.   Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families.

I.   Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs.

III.   Generation of Examples of Family-Centered Practices

IV.   Summary

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EXPLANATORY MATERIALS AND INSTRUCTIONAL GUIDE

Background Information

The use of family-centered practices in health care services, early intervention, and early childhood education programs has gained popularity in recent years as professionals have become increasingly aware of the importance of focusing on children's needs within, rather than separate from, the context of their families. Most developmental, educational, and health care delivery systems have centered their services and programs on children and have addressed their families only through involvement in educational or training programs.

Many programs and services for infants and young children with delayed development or disabilities continue to provide child-centered services. Adopting a family-centered perspective requires broad-based changes in attitudes, values, roles, and services. These changes may not be made easily by either professionals or the systems in which they are employed.

The nine principles of family-centered care that are outlined in this module (see Handout 1 for additional information) were adopted formally by federal and state Maternal and Child Health Divisions with specific reference to children with special health care needs (Surgeon General's Report, 1987; Shelton, Jeppson, & Johnson, 1989). Public Law 99-457, the 1986 Amendments to the Education of the Handicapped Act (now called the Individuals with Disabilities Education Act or IDEA), created a federal discretionary early intervention program for infants and toddlers with disabilities and their families. This landmark legislation created further support for the use of family-centered approaches within early intervention programs. In the years since the adoption of these two important federal public policy supports, many state level agencies have adopted state policy advocating adoption of family-centered practices.

Brief Overview of the Nine Principles

A central issue for families is their right to make decisions about their family members and especially about those who are too young to make or participate in their own decision-making. Families may interact with hundreds of professionals and have associations with numerous health, social service, and educational agencies over their lifetimes. Family members remain the constant in their children's lives while professionals'

associations with families are likely to be episodic and short-term. Families need to receive from, and share with, professionals unbiased information that will allow them to participate in informed decision making.

Family-centered practices can be implemented within all aspects of the service system when parents and professionals work together. Collaboration requires mutual respect, trust, and an equal partnership between parents and professionals. Parents can be involved in program evaluation and design of new programs and services, serve as members of agency boards or of parent advisory groups, and provide feedback to agency personnel about the quality and benefits of services provided. Parents' desires for their children are incorporated into planning documents and parents are encouraged to take leadership roles as members of early intervention evaluation or program planning teams. Parents should determine when planning meetings are held, where they are located, and who attends. Many of the facets of family/professional collaboration require adjustments in roles for professionals who may have learned to take full responsibility for all facets of program planning and operation. Higher quality services that are more responsive to family needs result when parents and professionals collaborate in all facets of service delivery.

The population of the United States is becoming more culturally diverse. No two families are identical. Families differ in their racial backgrounds, ethnicity, culture, and socioeconomic status. Families who are similar on any one of these characteristics will not necessarily be identical on the others. Two families of the same racial background will not necessarily share identical culture, tradition, or socioeconomic status anymore than two families of equal socioeconomic status will be of the same race, ethnicity, or culture. Professionals who act in a culturally sensitive and competent manner are respecting and honoring the diversity of America's families.

Each family is different. Families differ in their culture, values, and experiences. Some families may have extensive resources, while others may have few resources. Families have different priorities and concerns about themselves and their children and use varying coping strategies to deal with the stressors that may be present when children's health, development, or learning are compromised. Some family members may rely on physical strategies, such as exercise, to cope with difficulties in their lives. Others may use cognitive or spiritual coping strategies. Recognition of and respect

for family strengths and individuality is important if services and interactions are to be family-centered.

Families and professionals need to share information in order to gain a complete picture of family situations. The ways in which information is shared should be sensitive to family needs and circumstances. Professionals have knowledge about medical treatments and medications, interventions, equipment, caregiving strategies, advocacy, and many other areas. Families have information about their children and themselves, their family values, traditions, and experiences that are helpful to professionals. Family-identified needs and concerns are more likely to be addressed when families and professionals share information in complete and unbiased ways.

Parents of children with delayed development or disabilities may benefit from meeting and learning with other parents in similar circumstances. Veteran parents, those whose children are older or who have been through medical or health problems, often provide friendship, knowledge, support, and information for parents less experienced with raising a child with special needs. Early intervention programs and professionals should facilitate participation in family-to-family support when parents wish to meet other families. Family support groups may exist alone and not under the auspices of any agency, or agencies may facilitate establishment of support networks by accessing families to other families, providing facilities for meetings, or using other types of facilitating strategies.

Many existing services focus on only one aspect of a child's or family's life. Health services may focus on addressing the medical needs of an infant or child and may not address developmental or social needs. Developmental or educational services may ignore health, nutritional, social service, or other needs. All aspects of a child's development are integrally related. The compartmentalized approach inherent in service systems often results in fragmented delivery (and, sometimes, service gaps, as well). Social and emotional development of infants and young children are of prime importance and should not be secondary to other developmental therapies, education, health, or other interventions.

Many service systems are organized only to provide one type of service. Families may have needs for more than one type of service or support, including respite care, family-to-family support, financial assistance, health services, or early intervention/therapy services. These services and supports may be available only through interactions with and access to a wide variety of agencies or providers. When families' needs are best met through

multiple providers, coordination may be necessary. This coordination may be provided through an employed service coordinator or case manager or families may elect to coordinate or share in the coordination of services. Professionals can help families obtain the services and supports that families view as important and want to receive. Working with families, the service coordinator makes families aware of available resources and assists them in choosing and accessing those services that best address their needs.

Systems and services that are flexible, accessible, and responsive to family needs are those that are using family-centered practices. Allowing families to choose the services they wish to receive and to decide how often and where services best can be provided allows families to utilize services without compromising family priorities and functioning. Systems may have a great deal of difficulty with concepts such as parental choice or with providing a sufficient range of services that are fully responsive to family individuality. Designing flexible service systems that are responsive to family needs may mean that various educational, developmental, health, and social service agencies may need to work together to create what families need.

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Instructional Guide

Introduction to Session: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 1 - Objectives	**Overview of the Module:** Introduce the concept of family-centered by telling students that family-centered care is a trend in both health care and educational service provision for infants and young children due to research, legislative, and consumer perspectives. Research has demonstrated that families are more comfortable with their children when involved in the provision of services. Legislative underpinnings for implementation of family-centered approaches come from the Surgeon General's initiative in 1987, as well as from P.L. 99-457, which created a discretionary federal early intervention program. Consumer input into systems, services, and products has gained importance in recent years. Families are consumers of services for themselves and their children and have been instrumental in designing services that address their needs. **List and briefly review the objectives for the session.**

Overview of Family-Centered Principles: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 2 - Principles of Family-Centered Practices Handout 1 - Family-Centered Principles	**Principles of family-centered care** • Recognizing that the family is the constant in the child's life • Facilitating family/professional collaboration • Honoring the diversity of families • Recognizing family strengths and individuality and respecting different methods of coping • Sharing unbiased and complete information with families • Encouraging and facilitating family-to-family support • Understanding and incorporating developmental needs into service delivery systems • Implementing comprehensive policies and programs • Designing accessible systems that are flexible, culturally competent, and responsive

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Overview of Principle One: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 3 - Recognizing that the family is the constant in the child's life	**Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate** Discuss the fact that families have ultimate responsibility for children's health, developmental, and social-emotional needs over the lifespan. Talk about the importance of families' need to balance their children's developmental programming or health procedures within the context of their and their children's lives.

Overview of Principle Two: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 4 - Facilitating family/professional collaboration Handout 2 - Principles of family/professional collaboration	**Facilitating family/professional collaboration at all levels of service provision: services for an individual child; program development, implementation, and evaluation; and policy formation** A traditional role of professionals has been to dictate services based on professionally-identified goals, objectives, and preferences. In order to implement a family-centered philosophy, parents and professionals must work together to make decisions, determine services, plan interventions, and change systems.

Overview of Principle Three: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 5 - Honoring the diversity of families	**Honoring the racial, ethnic, cultural, and socioeconomic diversity of families** Families represent diversity -- in culture, traditions, ethnicity, race, socioeconomic status, values, preferences, dreams, and aspirations. Our country is becoming a diverse mixture of many different peoples of many different cultures. Honoring and respecting the diversity of families allows professionals to recognize and value the uniqueness of families and use this strength to support families and children.

Infants and Toddlers with Special Needs and Their Families

Overview of Principle Four: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 6 - Recognizing family strengths and individuality	**Recognizing family strengths and individuality and respecting different methods of coping** Most families have more strengths than needs and more successes than failures. Emphasize family-identified priorities and the importance of mobilizing resources to address family concerns. Each of us has different methods for coping with stress. Families, also, vary in the use of coping strategies. Discuss the types of coping strategies, including gathering of information (cognitive), praying (spiritual), exercises (physical), and being with friends and family (social).

Overview of Principle Five: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 7 - Sharing unbiased and complete information with families	**Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information** Discuss barriers to sharing information (such as the use of jargon) and strategies that facilitate information sharing (such as being sensitive to the types of information provided). Emphasize the importance of sharing information so that families can be informed decision-makers for their children.

Overview of Principle Six: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 8 - Encouraging and facilitating family-to-family support	**Encouraging and facilitating family-to-family support and networking** Discuss the buffering role that informal supports provide between individuals and life stressors. Families of children with developmental delays or disabilities have learned through experiences. These experiences provide valuable information for other families. Family-to-family support provides friendship, knowledge and information, experience, and mentorship.

Overview of Principle Seven: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 9 - Understanding and incorporating developmental needs into service delivery systems	**Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into service delivery systems** Infants and young children are diverse in their developmental abilities and needs. Families provide security, sustenance, emotional support, and stimulation for their members. They need time for leisure and recreation, rest and relaxation, and other family functions. Discuss the importance of providing services within the context of family functions.

Overview of Principle Eight: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 10 - Implementing comprehensive policies and programs	**Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families** The needs of families are different, diverse, and change over time. Discuss a range of comprehensive services that should be available for families, including: respite care; home care services; equipment loan; sibling support; transportation; service coordination; family-to-family support; financial assistance; and family counseling.

Overview of Principle Nine: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 11 - Designing accessible systems that are flexible, culturally competent, and responsive	**Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs** Different service options are necessary to address family priorities, needs, and concerns. The needs of all families and children are not likely to be met through only one service option (such as home-based or center-based services). Children and families interact with hundreds of professionals over their lifetimes. Discuss the role of professionals in providing families with a continuum of services that are easily accessed, coordinated, and designed flexibly to address individual needs.

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Generate strategies or illustrations of principles: 10 minutes	
Media/Materials	**Content and Learning Activities**
	Generation of strategies: Group discussion and problem-solving Divide the participants into 9 groups. Assign each group one of the nine principles. Ask them to generate as many strategies or ideas that typify the assigned principle as they can within 5 to 10 minutes of problem-solving. Bring the groups back together and ask each group to report one strategy. If time permits, go back through the groups a second or third time to list additional strategies. Reinforce groups for appropriate strategies and have the total group discuss pros/cons of strategies that seem less appropriate.

Summarization: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 2 - Principles of Family-Centered practices	List the principles a second time to review the information that has been presented and discussed in the class session. **Administer the evaluation.**

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PARTICIPANT EVALUATION

Ask the students to respond to the following statements by indicating which principle of family-centered care the statement most represents:

1. An early interventionist refers a parent of a toddler with cerebral palsy to a parent support group.

    _____

2. A hospital social worker provides parents of a newly diagnosed baby with Down syndrome with information on Down syndrome.

    _____

3. An early intervention team devises a coordinated intervention strategy to be worked on within the context of family routines.

    _____

4. The parents of a toddler with a vision impairment have indicated in conversations with the early interventionist that maternal grandparents are a tremendous help in caring for the children. The early interventionist invites the grandparents to the early intervention sessions and incorporates the grandparents' ideas on strategies in working with the toddler.

    _____

5. The early intervention center maintains a listing of parent organizations and facilitates opportunities for families to meet with other families.

    _____

6. The early intervention team provides parents with the option of an eligibility evaluation conducted at home or at the early intervention center.

    _____

7. The early intervention team provides the family with information from the assessment in family-friendly terms.

    _____

8. The early interventionist works with the day care staff so that a toddler with a hearing impairment can fully participate in all activities at the center and still receive the interventions necessary to help the child learn to speak.

    _____

9. The grandmother of a child with chronic respiratory failure invites her grandchild's nurse to attend a faith healing service because she hopes that the faith healer will be able to help her grandchild.

    _____

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RESOURCE LIST

Below is a list of instructional resources, including videotapes, learning activities, and other information that can be used to further illustrate family-centered practices.

Videotapes

Association for the Care of Children's Health. (1988). *Family-centered care.* Available from ACCH, 7910 Woodmont Avenue, #300, Bethesda, Maryland, 20814, 301-654-6549.

A 28-minute video that presents ways in which family-centered care is being implemented in a variety of settings.

Brown, C. *The family experience.* Available from Learner Managed Designs, Inc., 2201-K West 25th Street, Lawrence, Kansas 66047, 913-842-9088.

A 2-part, 45-minute video that provides information about families and allows professionals to respond more sensitively to families of infants born with prematurity and other conditions.

Pokorni, J. *Promoting family collaboration.* Available from Learner Managed Designs, Inc., 2201-K West 25th Street, Lawrence, Kansas 66047, 913-842-9088.

A 23-minute video that provides information on coping strategies used by families during children's long-term hospitalizations.

Print Materials and Curricula

Bennett, T., Nelson, D. E., & Lingerfelt, B. V. (1992). *Facilitating family-centered training in early intervention.* Tucson, AZ: Communication Skill Builders.

Crais, E. R. (1991). *A practical guide to embedding family-centered content into existing speech-language pathology coursework.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center.

Edelman, L. (Ed.). (1992). *Getting on board: Training activities to promote the practice of family-centered care.* Bethesda, MD: Association for the Care of Children's Health.

Family-centered institutes: Implementing a model for the preparation of family-centered practitioners. (1993, Winter). Burlington, VT: Parent to Parent of Vermont & The University Affiliated Program of Vermont, Center for Developmental Disabilities.

Hanft, B., Burke, J., Cahill, M., Swenson-Miller, K., & Humphry, R. (1992). *Working with Families: A curriculum guide for pediatric occupational therapists.* University of North Carolina at Chapel Hill, Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center. (Ordering information follows the Readings section)

Sparling, J. W. (1992). *A guide for embedding family information in an entry-level physical therapy curriculum.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center. (Ordering information follows the Readings section)

Winton, P. J. (1992). *Working with families in early intervention: An interdisciplinary preservice curriculum.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center. (Ordering information follows the Reading section)

Winton, P. J., Hallam, D., Auer, C., & Walters, W. (1991). *Training resources manual: Selected information on training materials for working with families in early intervention.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center. (Ordering information follow the Readings section)

Readings

Suggested reading materials are organized within each of the nine principles that typify family-centered practices.

Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate

Beckett, J. (1985). Comprehensive care for medically vulnerable infants and toddlers: A parent's perspective. *Equals in this partnership: Parents of disabled and at risk infants and toddlers speak to professionals* (pp. 6-13). Washington, DC: National Center for Clinical Infant Programs.

Burin, I. (1990). *Strengthening the role of families in state's early intervention systems.* Washington, DC: Mental Health Law Project.

Featherstone, H. (1980). *A difference in the family: Living with a disabled child.* New York: Basic Books.

Hunt, M., Cornelius, P., Leventhal, P., Miller, P., Murray, T., & Stoner, G. (1991). *Into our lives.* Akron, OH: Children's Hospital Medical Center of Akron, Family Child Learning Center.

Facilitating family/professional collaboration at all levels of health care: care of an individual child; program development, implementation, and evaluation; and policy formation

Bishop, K. K., Woll, J., & Arango, P. (1993). *Family/professional collaboration for children with special health needs and their families.* Burlington, VT: University of Vermont, Department of Social Work, Family/ Professional Collaboration Project.

Dunst, C. J., Trivette, C., & Deal, A. (1989). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.

Leviton, A., Mueller, M., & Kauffman, C. (1992). The family-centered consultation model: Practical applications for professionals. *Infants and Young Children, 4*(3), 1-8.

Honoring the racial, ethnic, cultural, and socioeconomic diversity of families

Hanson, M. J., Lynch, E. W., & Wayman, K. I. (1990). Honoring the cultural diversity of families when gathering data. *Topics in Early Childhood Special Education, 10*(1), 112-131.

Lynch, E. W., & Hanson, M. J. (1992). *Developing cross-cultural competence: A guide for working with young children and their families.* Baltimore, MD: Brookes.

Recognizing family strengths and individuality and respecting different methods of coping

Bailey, D. B. (1988). Rationale and model for family assessment in early intervention. In D.B. Bailey & R. J. Simeonsson (Eds.), *Family assessment in early intervention* (pp. 1-26). Columbus, OH: Merrill.

Kauffman, R. K., & McGonigel, M. J. (1991). Identifying concerns, priorities, and resources. In M. J. McGonigel, R. Kauffman, & B. Johnson (Eds.), *Guidelines and recommended practices for the individualized family service plan* (2nd ed.) (pp. 47-55). Bethesda, MD: Association for the Care of Children's Health.

Kjerland, L., & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In D. Gibbs & D. Teti (Eds.), *Interdisciplinary assessment of infants: A guide for early intervention professionals* (pp. 287-298). Baltimore, MD: Brookes.

Raver, S. A., & Kilgo, J. (1991). Effective family-centered services: Supporting family choices and rights. *Infant-Toddler Intervention, 1*(3), 169-176.

Shelton, T., Jeppson, E.S., & Johnson, B. (1989). *Family-centered care for children with special health care needs.* Washington, DC: Association for the Care of Children's Health.

Turnbull, A. P., Patterson, J. M., Behr, S. K., Murphy, D. L., Marquis, J. G., & Blue-Banning, M. J. (1993). *Cognitive coping, families, and disability.* Baltimore: Brookes.

Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information

Harrison, H. (1993, November). Principles for family-centered neonatal care. *Pediatrics, 92*(5), 643-650.

Healy, A., Keesee, P., & Smith, B. (1985). *Early services for children with special needs: Transactions for family support.* Iowa City, IA: University of Iowa.

Encouraging and facilitating family-to-family support and networking

Dunst, C. J., & Trivette, C. M. (1990). Assessment of social support in early intervention programs. In S. Meisels & J. P. Shonkoff (Eds.), *Handbook of early childhood intervention* (pp. 326-349).Cambridge, MA: Brookline Press.

Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into health care systems

Bailey, D. B. (1987). Collaborative goal-setting with families: Resolving differences in values and priorities for services. *Topics in Early Childhood Special Education, 7*(2), 59-71.

Winton, P. (1990). Promoting a normalizing approach to families: Integrating theory with practice. *Topics in Early Childhood Special Education, 10*(2), 90-103.

Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families

Dunst, C. J. (1990). *Family support principles: Checklists for program builders and practitioners.* Family Systems Intervention Monograph Series (Vol. 2, No. 5). Morganton, NC: Western Carolina Center, Family, Infant, and Preschool Program.

Oster, A. (1985). Keynote address: Comprehensive care for medically vulnerable infants and toddlers: A parent's perspective. In *Equals in this partnership: Parents of children with disabilities and at risk infants and toddlers speak to professionals* (pp. 26-32). Washington, DC: National Center for Clinical Infant Programs.

Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs

Kaiser, A. P., & Hemmeter, M. L. (1989). Value-based approaches to family intervention. *Topics in Early Childhood Special Education, 8*(4), 72-86.

Vohs, J. R. (1989). Perspective - Vision and empowerment. *Infants and Young Children, 2*(1), vii-x.

The following curricula and training materials have been developed by the Carolina Institute for Research on Infant Personnel Preparation. Send requests and make checks payable to:

Frank Porter Graham Child Development Center
CB# 8180
The University of North Carolina
Chapel Hill, NC 27599-8180
Attention: Lori Brandon

Please note that we cannot accept cash, credit cards, phone orders, or purchase orders!

The Families We Serve: Case Studies in Early Intervention. P. J. McWilliam (1992). A collection of cases in early intervention for use in preservice and inservice training. Also provides brief guidelines for instruction using the case method. $15.00

Working with Families in Early Intervention: An Interdisciplinary Preservice Curriculum. P. J. Winton (revised 1992). A preservice curriculum for graduate students consisting of 11 modules, including teaching objectives, suggested student activities, references, and audiovisual resources. $15.00

Communicating with Families in Early Intervention: A Training Module. P. J. Winton (1991). Training module, related to communication skills, consisting of objectives, readings, and teaching activities. Included are role play vignettes, strategies for videotaping for self-assessment & peer feedback, and an observational rating scale. $3.00 [This module is included in *Working with Families in Early Intervention: An Interdisciplinary Preservice Curriculum.*]

A Practical Guide to Embedding Family-Centered Content into Existing Speech-Language Pathology Coursework. E. R. Crais (1991). A curriculum for graduate training programs interested in embedding family-centered content into existing speech-language pathology (SLP) courses. Includes a rationale for using a family-centered approach to assessment and collaborative goal-setting & 4 modules with student objectives, content outlines, suggested readings, references, and materials for development of transparencies and handouts. $10.00.

Service Coordination for Early Intervention: Parents and Professionals. L. N. Zipper, M. Weil, & K. Rounds (1992). Examines issues relevant to service coordination in early intervention including the historical and legislative framework, families in early intervention, parent/professional partnerships, the role of the service coordinator, the service coordination process, systems for service coordination, interprofessional collaboration, and personnel preparation for service coordination. $10.00

Publications & Materials Catalogue is available upon request.

Available Late Summer, 1992:

Service Coordination in Early Intervention: A Manual for Parents. L. N. Zipper. C. Hinton, M. Weil, & K. A. Rounds. This guide for parents explains the process of service coordination and describes the role and functions of the service coordinator. It also provides suggestions for handling problems that can arise. $3.00

Embedding Family-Centered Information Into an Entry-Level Physical Therapy Curriculum. J. W. Sparling (1992). Includes goals, objectives, and strategies (including readings and overhead materials) for four courses: Human Growth and Development, Clinical Education I, Pediatrics, and Psychiatry and Mental Health. An overall need and philosophy statement supports the serial presentation of material emphasizing the family as the unit of health. Any one course or units within any course can be extracted and embedded into an existing curriculum. $15.00

Working with Families: A Curriculum Guide for Pediatric Therapists. B. Hanft, R. Humphry, J. Burke, M. Cahill, & K. Swenson-Miller (1992). This curriculum is designed as a nine module unit for educating therapists about working with families who have children with special needs. Each unit contains learning objectives, discussion points, implications for practice, recommended readings and teaching resources. It can be used by either preservice educators, fieldwork supervisors or continuing education coordinators. Although designed to train pediatric therapists, much of the material is applicable for working with families across the life span. $10.00

SUGGESTED ACTIVITIES FOR EXPANSION OF MODULE CONTENTS

Activities may be carried out in separate sessions, used to expand the **Family-Centered Practices: An Introduction** module into a longer than 1-hour session, or embedded within the module to illustrate principles of family-centered practices.

Activity 1: Values Clarification	
Purpose	To allow participants to reflect on their own values and on the assumptions they make about the values of the families with whom they work. This is a good opening session activity and can be inserted easily within this module following the Introduction to the principles of family-centered practices.
Activity Sequence	See following pages
Accessing Resources	n/a
Length	20 minutes
Materials	Paper/pencils; Index cards; Flipchart/markers; Tape
Source	This activity is copied directly from *Getting on board: Training activities to promote the practice of family-centered care*, by L. Edelman (Ed.), 1991, Bethesda, MD: Association for the Care of Children's Health.

ACTIVITY

3
A Values Clarification Exercise

PURPOSE	In this activity, participants first examine their own values, and then are asked to reflect on the assumptions they make about the values of the families they work with.

This activity is a good opening activity for family-centered care training. |
TIME REQUIRED	Allow about 20 minutes to conduct this activity.
SUGGESTED GROUP SIZE	From 5 - 30 participants; with careful planning, we have used it successfully with much larger groups.
LEARNING EXPERIENCES	Discussion, individual and large group exercise, summary.
SUPPLIES/EQUIPMENT	❏ Paper and pencils
❏ 5 index cards per participant
❏ Flipchart
❏ Markers
❏ Tape (to secure flipchart pages on the wall)
SOURCE	Contributed by Larry Edelman, adapted from an activity developed by James Gardner, Ph.D., Chief Executive Officer, Accreditation Council on Services for People with Developmental Disabilities; and Michael Chapman, Director, Office of Community Program Development, The Kennedy Institute.

A Values Clarification Exercise_____

Introduce the Activity	■ **Tell the Group:** "Values play an important part in the kind of work that we do. Let's use this activity to better understand our own values and how we regard the values of the families we work with."
Individual Exercise	■ **Ask the participants to work alone for a minute or two:** "Write down the five things that are most important to you — that you value above all else in life — that are your priorities."
Large Group Exercise	■ **When you see that everyone is finished, tell the group:** . . "Let's make a list of the things that you've identified as most important to you, that you value most in life." ■ **Generate a list:** On a flipchart, generate a list from the group by having the participants offer their values. You can start by asking a couple of volunteers to share their entire lists. Then ask the rest of the group to offer any of their responses that no one has said yet. At the conclusion, you may include any of your own values that did not surface from the group. (Examples of responses that often come up include: family, health, religion, God, work, equality, love, money, making a contribution, respect, self-respect, freedom, choice.)
Individual Exercise	■ **Pass out five index cards to each person.** ■ **Tell the group:** "Here's another chance. Take a moment to study the list we've made. Maybe there are some values on the list that you didn't consider, but would like to include now. Choose five. Write one on each of the five cards. In choosing these five, you're saying that you'll live without the others."

A Values Clarification Exercise _____

■ When you see that everyone is finished, tell the group:

"Study the five values you chose. You can only keep two of them and must give up the other three. You'll have to live without the ones you give up. Get rid of the three you don't choose to keep. Put them beyond your reach."

■ Tell the group:

"I have a deal for you. Here's one last chance. You can trade one of the cards you kept for two of the ones you put aside. Any takers? Take a second to decide and trade if you like."

Large Group Exercise

■ Tell the group:

"Let's tally up the values that we kept."

■ Make a tally of the values:

Have participants, in turn, tell the group the values they kept. Use hash marks to track the number of responses for each of the values on the original list on the flipchart.

Summarize

■ Refer to the tally of values and offer these concluding remarks:

• Ask rhetorically:

"Could anyone else have chosen for you the values you chose today? I don't think so. These are your values. Only you can determine them for yourself."

• Ask rhetorically:

"Now that we've looked at our own values, let's think about the people we serve. Do we respect their values as we want our values to be respected? Or, do we assume that because they have a family member with special needs, they don't have the right to decide their values for themselves?"

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● Conclude:

"We need to ask ourselves: What do our programs do to support the values of the families we work with? The challenge of family-centered care is to provide services in ways that support the values and priorities of the families that we work with."

Some Tips on Using This Activity

■ When doing this activity as part of a longer program, in order to save time, we often pass out the five cards in advance, along with other materials in a folder.

■ To conduct this activity efficiently with a very large group, we like to use two group leaders: one to guide the group discussion, while the other writes down the group responses.

■ We like to fit the entire list of values on one flipchart page. We use two different colors of markers — one color to write the original list of values, and the other to indicate the hash marks for the final values selected. For instance, we use a black marker to list the values, and a red marker for the hash marks. This helps to keep all of the information on one page. We tape the list to a wall for later reference. If later discussions warrant, we refer back to the list to refocus the group on the importance of respecting families' values, just as we want our own values to be respected.

Ideas for Follow-up

■ Many of the other activities in this collection are good follow-ups to this activity. Here are a couple of ideas:

● *Recognizing Family-Centered Care*
● *Connect the Dots*
● *Use of Films and Media*

Activity 2: Recognizing Family-Centered Care	
Purpose	To promote participant understanding of the differences between family-centered, child-centered, or system-centered approaches. This activity can follow the review of each of the nine family-centered principles in order to provide participants with a background against which to judge each of the descriptive statements. Practicing practitioners or students who have completed field-based experiences in early intervention programs may be able to complete this activity without an introduction to the principles.
Activity Sequence	See following pages
Accessing Resources	n/a
Length	60 minutes
Materials	Handouts and transparencies (attached); Pencils; Overhead projector and screen; Overhead markers
Source	This activity is copied directly from *Getting on board: Training activities to promote the practice of family-centered care*, by L. Edelman (Ed.), 1991, Bethesda, MD: Association for the Care of Children's Health.

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A C T I V I T Y

4 Recognizing Family-Centered Care

PURPOSE
This activity helps professionals recognize and understand the driving forces that shape the services they provide.

We have found this exercise to be very useful in helping participants understand family-centered care and how to distinguish it from child-centered and system-centered approaches to delivering services.

TIME REQUIRED
Allow 40 - 60 minutes to conduct this activity.

SUGGESTED GROUP SIZE
From 5 - 50 participants.

LEARNING EXPERIENCES
Discussion, small group (or individual) exercise, large group exercise, summary.

SUPPLIES/EQUIPMENT
Handouts:
❏ *Introduction to the Exercise*
❏ *Recognizing the Driving Forces of Services*

Transparencies:
❏ *Driving Forces of Service Delivery*
❏ *Recognizing the Driving Forces* (two pages)

Supplies:
❏ Pencils or pens
❏ Overhead markers
❏ Overhead projector and screen

SOURCE
Contributed by Larry Edelman, developed by Project Copernicus.

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Introduce the Activity

■ Pass out the *Introduction to the Activity* handout.

Ask the participants to read it individually.

■ Discuss and emphasize the main points of the *Introduction to the Activity* handout:

- "Family-centered care requires that we look closely at our current practices: Why do we do things this way? Is this the only way possible? Is this the best way? Do we do it this way because it's always been done this way?"

- "Once we recognize the forces that drive our programs and services, it will be easier to visualize new possibilities."

Review Core Concepts

■ Discuss the concept of the driving forces:

- "Three different forces can influence the programs and services that we offer, as well as the way that we offer them. Let's take a look at these forces."

■ Discuss the driving forces. Use the *Driving Forces of Service Delivery* overhead transparency.

Reveal them one at a time on the overhead (cover the others with a sheet of blank paper). For each one, discuss the definition and ask a volunteer from the group to suggest a hypothetical example of how a service could be driven by that force. Examples are provided below for each of the driving forces using nutritional services as the focus. You can use these examples, or think of others relevant to the group.

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Recognizing Family-Centered Care_____

1. **System-Centered Driving Force:** the strengths and needs of the system drive the delivery of services. Example: Test results must be sent ahead before a visit can be scheduled with a nutritionist. This "rule" reflects a requirement of the system or perhaps a job function within that system.

2. **Child-Centered Driving Force:** the strengths and needs of the child drive the delivery of services. Example: The nutritionist assesses the child, designs a meal plan, and gives it to the parents. Although this approach addresses the child's clinical needs as identified by the nutritionist, the family's dietary preferences, cultural practices, and resources have not been considered.

3. **Family-Centered Driving Force:** the priorities and choices of the family drive the delivery of services. Example: The nutritionist asks to meet with the parents to jointly design a meal plan consistent with the family's resources and preferences. This addresses the priorities and choices of the family.

■ **Summarize:**

"These three driving forces influence the services we provide and the way we provide them. In the following activity we'll practice how to recognize these driving forces in programs and services."

Small Group Exercise

■ **Have the participants break into small groups.** (We suggest groups of five.)

■ **Tell the groups:**

● that you are going to pass out a sheet with some statements;

- to discuss the statements in their groups and come to agreement as to whether each statement is system-centered, child-centered, or family-centered, indicating their choices by the letters S, C, or F;
- to be prepared to justify their answers.

■ Pass out the handout *Recognizing the Driving Forces of Services* and ask them to begin:

- While they are doing the activity, you may want to walk around and tune in, stopping to help any groups that are stuck. We are often asked if groups can choose more than one driving force for a statement. We reply that it's okay as long as the group agrees and can justify its answer.

- When most of the groups are close to finishing, let the participants know they have just a couple of minutes to finish up.

Large Group Discussion

Important Note: Read the next section, *Useful Tips for Guiding the Discussion,* before leading this activity. It will help you guide the discussion and address the issues and controversies that may come up.

■ Have the participants stay in their small groups, but focus their attention on the projection screen.

■ Use the *Recognizing the Driving Forces* overhead transparencies.

Discuss each statement. Reveal the statements one at a time on the overhead — cover the others with a sheet of blank paper. Ask a group to volunteer it's answer for the statement in question and the reasons for that choice. Ask if any other groups came up with a different answer. Discuss any issues and controversies that come up. Write the answer on the overhead transparency.

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■ Continue until all of the statements have been discussed.

Summarize

■ Offer these concluding remarks after all the statements have been discussed:

"Family-centered care is neither a destination, nor something that one instantly 'becomes.' It is a continual pursuit of being responsive to the concerns, priorities, and resources of families."

"Family-centered care requires that we recognize the driving forces behind our programs and services. We need to recognize when our services are not family-centered and strive to make them as family-centered as possible."

"We need to look closely at our programs and services and ask the questions:
    "Is this the only way we can do it?,"
    "Is this the best way to do it?," or
    "Are we doing it this way because it's always been done this way?"

"Our task, then, is to apply this approach to our work. If we can recognize the forces that drive our programs and services, then it will be easier to visualize new possibilities and ask: "What can we do to offer our services in the most family-centered way possible?"

Tips for Guiding the Discussion

Some Common Situations: Part of the art of leading this kind of discussion is to deal gently and constructively with challenging ideas. Here are some common situations and ways that we've responded to them.

Situation   The participants say: "There's not enough information in the statement for us to make up our minds!"

Response   We agree and ask: "What information do you need to assume in order to recognize the driving force?" and then proceed from there.

Situation   The participants say: "It could be either child-centered or system-centered!"

Response   We agree and explain that some of the statements were designed to be ambiguous in order to stimulate discussion. We ask: "How could you reword this statement so that it could be clearly interpreted as family-centered (or child-centered, or system-centered)?"

Situation   The group does not come to agreement in the large group discussion.

Response   We encourage debate by looking at the justifications for the suggested answers. We ask: "What assumptions did you make in arriving at your answer?" Agreement usually occurs when the group agrees on common assumptions. Sometimes a statement lends itself to two different answers, each with its own valid justification.

Situation   The leader feels the group is way off the mark, e.g. the group feels a statement is family-centered when the example is clearly not driven by the family's priorities and choices.

Response   We ask for justifications. We often ask: "Imagine yourself as a family member in this situation — would this meet your needs?" or "Can you think of a situation in which this might not be responsive to families' choices and priorities?"

Recognizing Family-Centered Care

Suggested Answers

Remember: The value of this activity lies in the discussion of the concepts rather than in getting the right answers. In fact, many of the statements could have two "right" answers, depending on how they are justified. The participants will come up with answers and justifications based on their experiences, but below are suggested answers with some examples of justifications.

S   A family must bring their child to the office for case management services.
What if the family can't get to the office? This is a rule for the convenience of the system.

S   A complete assessment is done on a child and family.
This one is very subtle. The word "on" implies that someone is doing something "on" the family, not "with" them. From this information, we don't know if the family wanted an assessment or if the assessment was just standard procedure.

F   Occupational therapy sessions are arranged according to a family's schedule.
Services are scheduled according to a family's availability. This reduces the possibility that the therapy might conflict with other family activities.

F/C   Child care is provided for the brother and sister while the child who has special needs receives treatment.
This recognizes and supports the needs of the family as a whole — the child who has special needs, brothers and sisters who need attention too, and parents who may need help with child care. However, if this is a rule rather than an option, it could prevent brothers and sisters from participating in treatment, and could be viewed as child-centered.

S   The office hours of the dentist are Monday through Friday, 9:00 a.m. - 4:00 p.m.
Rigid, non-flexible hours make it difficult for families to use services.

S/C   A physical therapist sends the order for a seating device home with the child.
The therapist may feel the child needs the device, but the way the order was delivered does not necessarily involve the family in choosing the device or understanding the need for it.

S   Transportation to the clinic is available from 9:00 a.m. - 5:00 p.m.
The limited hours of operation probably are not adequate to enable many families to get to the clinic without a great deal of trouble.

F/S   Parent support groups may use the facility's conference room in the evenings.
This may be in response to families' requests for meeting space. However, if the families are told they can only use the room in the evening, it could be seen as system-centered.

Recognizing Family-Centered Care _____

F/S A local school board's planning committee consists of professionals, parents, and
     representatives from the community.
     If parent and community representatives have real and meaningful input in planning how
     the educational services will be delivered, this example can be viewed as family-centered.
     However, if representation is only tokenism, this example can be viewed as system-
     centered.

S   A child's medical records are available 3-5 days after a release of information is received.
     This is a rigid time-frame that reflects a limitation of the system. What if the parents need
     the information immediately? Why must they wait 3-5 days?

S/C/F A speech therapist comes to the home twice a week for a one hour session with a child.
     This is another tricky example. It is family-centered if a parent requested that services be
     delivered in this way. It is child-centered if the session is only for the child and precludes
     the involvement of other family members. If there are no options for services to be
     delivered elsewhere, or scheduled differently, it is system-centered.

S   A care plan developed by a multidisciplinary team is given to the parent.
     There is no evidence that parents participated in the development of the plan. If we assume
     that parents were part of the team and participated rather than just being given a
     typed copy for signature, this example could be regarded as family-centered.

S   School is closed for a day so that parent/teacher conferences can be held.
     This situation is difficult for at least two reasons: working parents have to miss work, and
     child care has to be arranged for children who are off from school.

F   Parents choose to send their child with diabetes to a church camp instead of a special
     camp for children with diabetes.
     The word "choose" indicates that the parents had options and made their decision.

C   A hospital social worker arranges for all of the medical equipment ordered by a
     physician for a child.
     If the physician and social worker made these decisions without discussing it with the
     family, it is child-centered. If the family collaborated with the physician on the need and
     choice for equipment, and requested that the social worker make the arrangements, this
     example could be viewed as family-centered.

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Customizing the Exercise

Recognizing Family-Centered Care was developed for a broad audience including direct service, supervisory, and administrative staff who serve families with children who have special needs. To address this multidisciplinary audience, the activity includes a wide variety of service delivery examples, so that each participant will find at least some examples directly relevant. Although this activity has been used successfully with a wide variety of groups, you may choose to customize it for groups whose members are all from one agency, discipline, or field.

The activity can be customized by simply revising the example statements to be more relevant to the participants. Start by looking over the examples and picking out the ones that you feel need to be revised for your group. These statements can either be slightly reworded or completely rewritten. Remember that if you revise the statements, you will need to revise both the handout and the overhead. If you do create your own version, we would love to see it! Please send a copy to us.

To illustrate, consider the following two examples of how the statements can be customized. In the first example, the statements were customized for staff who work at a hospital. In the second example, the statements were revised for a group who work at an early intervention program.

Sample Statements for Hospitals:

F   Bulletin boards in family waiting areas have information about family-to-family support.

F   A child life specialist teaches a father how to use distraction and other coping strategies with his daughter in preparation for a bone marrow aspiration.

S   The hospital's visiting policy states that visiting hours are open for parents in the NICU except for one hour at each of the three daily shift changes.

S   The hospital's ethics committee has ten members, each representing different departments or disciplines. A parent of a child with special needs is appointed as the eleventh member.

S   After getting permission from a physician, families have access to the hospital library.

F   Families participate as faculty in the hospital orientation program for new employees.

S   In developing a new step-down unit, the hospital administration invites families to comment on the final plans.

Recognizing Family-Centered Care _____

C   A staff nurse explains to a mother that hospital policy allows a parent to stay during an IV start and says that her child needs her to be there.

C   A social worker's job description states that "she/he is to identify the needs of each child discharged on a ventilator."

Sample Statements for Early Intervention Programs:

F   Child care is available for brothers and sisters when a mother brings her toddler to the early intervention program for developmental services.

C/F   The physical therapist gives a parent an order for an adaptive seating device.

F   The early intervention program's planning committee consists of staff, families, and community representatives.

F   The early intervention program's planning committee consists of staff, families, and community representatives.

C/F   The primary service provider comes to a family's house twice a week for a one hour session with the child.

S   The early intervention program is closed to families for a week every February so that staff can attend inservice training sessions.

F   Twice a month, the parents choose to take their child to baby gymnastics at the Y rather than bring him to the early intervention program.

S/F   The service coordinator arranges for all of the medical equipment ordered by the physician for a medically fragile infant who is being released from the hospital.

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Recognizing Family-Centered Care

Handouts and Overhead Transparencies

Handouts

On the next two pages are handouts ready for you to photocopy and use in conducting the activity.

1. *Introduction to the Activity*
2. *Recognizing the Driving Forces of Services*

Overhead Transparencies

Following the handouts are overhead transparencies ready for you to photocopy and use in conducting the activity.

1. *Driving Forces of Service Delivery*
2. *Recognizing the Driving Forces* (two pages)

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Introduction to the Activity

To paraphrase Tom Peters' description of excellence, family-centered care is not a final destination, but a continual pursuit. The philosophy of family-centered care describes a collaborative relationship between parents and professionals in the *continual pursuit* of being responsive to the concerns, priorities, and resources of families with children who have special needs. This philosophy has received increasing attention and acceptance in recent years. As both families and professionals embrace this notion, one of the challenges that remains is to apply the philosophy of family-centered care to practice. Our challenge is to envision and pursue new ways that we can provide services to families, ways that are more responsive to families' choices.

Family-centered care requires that we look closely at what we do now and envision what we can create. A good place to start is to look closely at our current practices and ask questions such as: Why do we do things this way? Is this the only way possible? Is this the best way? Do we do it this way because that's the way its always been done?

Recognizing Family-Centered Care is an activity designed to help professionals recognize and understand the driving forces that shape the services they provide. If we can recognize the forces that drive our programs and services, then it will be easier to visualize new possibilities.

Recognizing the Driving Forces of Services _____

Driving Forces:

S   System-centered: the strengths and needs of the system drive the delivery of services

C   Child-centered: the strengths and needs of the child drive the delivery of services

F   Family-centered: the priorities and choices of the family drive the delivery of services

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____ A family must bring their child to the office for case management services.

____ A complete assessment is done on a child and family.

____ Occupational therapy sessions are arranged according to a family's schedule.

____ Child care is provided for the brother and sister while the child who has special needs receives treatment.

____ The office hours of the dentist are Monday through Friday, 9:00 a.m. - 4:00 p.m.

____ A physical therapist sends the order for a seating device home with the child.

____ Transportation to the clinic is available from 9:00 a.m. - 5:00 p.m.

____ Parent support groups may use the facility's conference room in the evenings.

____ A local school board's planning committee consists of professionals, parents, and representatives from the community.

____ A child's medical records are available 3 - 5 days after a release of information is received.

____ A speech therapist comes to the home twice a week for a one hour session with a child.

____ A care plan developed by a multidisciplinary team is given to the parent.

____ School is closed for a day so that parent/teacher conferences can be held.

____ Parents choose to send their child with diabetes to a church camp instead of a special camp for children with diabetes.

____ A hospital social worker arranges for all of the medical equipment ordered by a physician for a child.

Driving Forces of Service Delivery

System-centered: the strengths and needs of the system drive the delivery of services

Child-centered: the strengths and needs of the child drive the delivery of services

Family-centered: the priorities and choices of the family drive the delivery of services

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Recognizing the Driving Forces

_____ A family must bring their child to the office for case management services.

_____ A complete assessment is done on a child and family.

_____ Occupational therapy sessions are arranged according to a family's schedule.

_____ Child care is provided for the brother and sister while the child who has special needs receives treatment.

_____ The office hours of the dentist are Monday through Friday, 9:00 a.m. - 4:00 p.m.

_____ A physical therapist sends the order for a seating device home with the child.

_____ Transportation to the clinic is available from 9:00 a.m. - 5:00 p.m.

_____ Parent support groups may use the facility's conference room in the evenings.

Recognizing the Driving Forces (Continued)

_____ A local school board's planning committee consists of professionals, parents, and representatives from the community.

_____ A child's medical records are available 3 - 5 days after a release of information is received.

_____ A speech therapist comes to the home twice a week for a one hour session with a child.

_____ A care plan developed by a multi-disciplinary team is given to the parent.

_____ School is closed for a day so that parent/teacher conferences can be held.

_____ Parents choose to send their child with diabetes to a church camp instead of a special camp for children with diabetes.

_____ A hospital social worker arranges for all of the medical equipment ordered by a physician for a child.

Activity 3: Family Sculpting	
Purpose	To promote participant understanding of: (1) family systems concepts and (2) how their own experiences in growing up in a family impact on their interventions and interactions with families in early intervention programs. This activity requires skill and responsibility on the part of the instructor, as participation may reveal family issues that participants have not resolved successfully concerning their own membership in families. The instructor may need to be accessible to participants for follow-up. The activity may be conducted between the *Importance of the Family* and the *Family-Centered Practices: An Introduction* modules or may follow the *Family-Centered Practices: An Introduction* module.
Activity Sequence	See following pages
Accessing Resources	n/a
Length	40 minutes
Materials	Colored construction paper; Glue; Scissors; Pens
Source	This activity is copied directly from *Working with families in early intervention: An interdisciplinary preservice curriculum*, by P. J. Winton, 1992, Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center.

1.*Family Sculpture Project: Students might be asked to do this project for homework. For some students this assignment may be difficult, especially if they are in the middle of a family crisis. It is important to stress that sharing the information will be on a voluntary basis. Students will need colored construction paper, glue, scissors and pens in order to do this project. Refer to the Wedemeyer and Groterant (1982) article for pictorial examples of this project.

OBJECTIVES OF PROJECT

- To provide students with an opportunity to apply the basic concepts of family systems theory to their own family
- To provide students with a context for discussing the family system concepts

DIRECTIONS FOR STUDENTS

1. Decide what family you will picture (family of origin or current family). If you have more than one family for some reason, you may do both.

2. Trace and cut out circles from the construction paper, making enough for yourself and each person or set of persons or things you want to include. There are no restrictions on whom you include or how you symbolize them. (Parents, siblings, neighbors, pets, your father's golf game-whoever or whatever has a significant effect on the family.) If you wish you may vary size, shape, or color of the units to express yourself more fully.

3. Label each circle. A single circle may have one name or more than one if you see those people/things as a unit.

4. Arrange the circles on a large piece of colored paper so they express the relationships you feel in your family. When you feel comfortable with the total arrangement, firmly glue them in place.

5. Draw any boundary or connecting lines you feel complete the picture.

6. Please bring your project to class if you feel comfortable doing so. Volunteers will be asked to share their sculpture.

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*Wedemeyer, N., & Groterant, H. (1982). Mapping the family system: A technique for teaching family systems theory concepts. *Family Relations.* 31. 185-193.

Internal boundaries: The discussion above highlights how intervention might affect internal boundaries (cite examples given in above discussion). The Rolland article describes how a disability might affect internal boundaries. The following questions might be posed:

1. How do internal boundaries change in response to life cycle events and how do disruptions in life cycle events created by disability impact internal boundaries?

2. What is impact of supporting or supplanting internal boundaries through intervention efforts?

External boundaries: Some families have rigid external boundaries and this will affect relationship with outside helpers. In Module 4 we will discuss further the impact of intervention on families...both positive and negative consequences.

c. FAMILY HIERARCHIES—This basically means who is in charge in this family...who has power and authority. Cite examples of unexpected sources of family power...i.e., the ghost of a dead relative. The following question might be posed: Why is it important to consider which family members have power and authority?

d. INTERACTION OF CONCEPTS—Several types of development occur simultaneously: child's individual development: family as it evolves in its own life cycle: and changing course of physical condition and unfolding adaptation to it. All of this is influenced by social context and cultural variations. Refer back to ecological model.

PARTICIPANT HANDOUTS

Handout 1: Principles of Family-Centered Care

Handout 2: Principles of Family/Professional Collaboration

Handout 3: Participant Lecture Notesheets

Family-Centered Principles

- Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate

- Facilitating family/professional collaboration at all levels of service provision: services for an individual child; program development, implementation, and evaluation; and policy formation

- Honoring the racial, ethnic, cultural, and socioeconomic diversity of families

- Recognizing family strengths and individuality and respecting different methods of coping

- Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information

- Encouraging and facilitating family- to-family support and networking

- Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into service delivery systems

- Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families

- Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs

Principles of Family/Professional Collaboration

- Promotes a relationship in which family members and professionals work together to ensure the best services for the child and the family

- Recognizes and respects the knowledge, skills, and experience that families and professionals bring to the relationship

- Acknowledges that the development of trust is an integral part of a collaborative relationship

- Facilitates open communication so that families and professionals feel free to express themselves

- Creates an atmosphere in which the cultural traditions, values, and diversity of families are acknowledged and honored

- Recognizes that negotiation is essential in a collaborative relationship

- Brings to the relationship the mutual commitment of families, professionals, and communities to meet the needs of children with special health needs and their families

Note. From *Family/professional collaboration for children with special health needs and their families*, by K. K. Bishop, J. Woll, & P. Arango, 1993, Burlington, VT: University of Vermont, Department of Social Work, Family/Professional Collaboration Project.

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By the end of this module, the participant will be able to:

- List and define the nine principles of family-centered care

- Describe one activity or strategy that characterizes each of the nine family-centered principles

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Lecture Notes

Family-Centered Principles

- Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate
- Facilitating family/professional collaboration at all levels of service provision: services for an individual child; program development, implementation, and evaluation; and policy formation
- Honoring the racial, ethnic, cultural, and socioeconomic diversity of families
- Recognizing family strengths and individuality and respecting different methods of coping
- Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information
- Encouraging and facilitating family- to-family support and networking
- Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into service delivery systems
- Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families
- Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs

Note. From *Overview of family-centered service coordination*, by L. Edelman, S. S. Elsayed, & M. McGonigel. 1992. St. Paul, MN: Pathfinder Resources, Inc.

Lecture Notes

> Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate

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Lecture Notes

Facilitating family/
professional collaboration
at all levels of service
provision:

- services for an
  individual child

- program development,
  implementation, and
  evaluation

- policy formation

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Lecture Notes

Honoring the racial, ethnic, cultural, and socioeconomic diversity of families

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Lecture Notes

Recognizing family strengths and individuality and respecting different methods of coping

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Family-Centered Transparency #7

Sharing with parents,
on a continuing basis
and in a supportive
manner, complete and
unbiased information

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Encouraging and facilitating family-to-family support and networking

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Family-Centered Transparency #9

Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into service delivery systems

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Implementing
comprehensive
policies and programs
that provide emotional
and financial support
to meet the needs of
families

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Designing accessible
health care systems
that are flexible,
culturally competent,
and responsive to
family-identified
needs

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Infusion Modules

Helping Infants, Toddlers, and Young Children to Grow, Learn, and Participate in Their Natural Environments

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ASSESSMENT for Early Intervention: New Purposes, New Practices

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OBJECTIVES

By the end of this module, the participant will be able to:

A.   State the basic definition of assessment for early intervention.

B.   Answer the question: Who should do assessment and make decisions, and why?

C.   Identify the major decisions that assessment helps us make.

D.   Describe four major factors or dimensions that are assessed.

E.   List aspects of early development that confound definitive assessment and diagnosis.

F.   Describe issues and problems related to conventional assessment of infants and toddlers.

G.   Name several methods used to collect and record information.

H.   Explain norm, curriculum, performance, and ecological-based assessment.

I.   List advantages of curriculum-based assessment.

J.   Describe team models and arrangements for assessment.

K.   State options for eligibility assessment.

L.   Explain how curriculum-based assessment is ideal for program planning and monitoring.

M.   Describe the four major standards for assessment.

N.   Describe the strength of "convergent assessment."

O.   State how the specific Recommended Practices are consistent with a family-centered approach.

OUTLINE

This workshop is designed to offer fundamentals of Assessment for Early Intervention. The content is an orientation to the issues and recommended practices rapidly emerging in the field of early intervention. Obviously, much has been neglected and omitted and selective material has been included. Resources listed at the end of the module will allow those interested to pursue the topic in depth.

I.   Basic

    A.   What is assessment?
    B.   Who does assessment and makes decisions?
    C.   What decisions does assessment help us make?
    D.   Close-up on eligibility
    E.   Close-up on program planning and progress monitoring

II.   Factors that are assessed

    A.   Developmental milestones
    B.   Functional behavior
    C.   Atypical behavior
    D.   Child context

III.   Issues related to conventional assessment

    A.   Features of early development
    B.   Problems with standardized, formal assessment materials and procedures

IV.   Assessment methods

    A.   Methods and basics of information
    B.   Recording assessment
    C.   Norm, curriculum, performance, and context-based assessment
    D.   Close-up on curriculum-based assessment
    E.   Team models and arrangements

V. Four standards for assessment

    A.   Treatment validity (utility)
    B.   Social validity (acceptability)
    C.   Convergent validity (inclusiveness)
    D.   Consensual validity (agreement)

VI. Summary and checklists

    A.   Four standards
    B.   Recommended practices

Instructional Guide

Overview of objectives: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 1 - Session Objectives Handout 1 - Session Objectives	Briefly review the scope of session content, and emphasize that this session is designed only to overview *the importance of assessment in early intervention* and to *introduce major concerns and procedures.*

Introduction to Session: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 2 - What is Assessment?	Professionals should understand the new conception of assessment – as information that permits valid decision-making. Assessment information must be reliable, systematic, and inclusive so that decisions based on it are useful and acceptable.

Responsibilities for Assessing and Deciding: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparencies 3 and 4 - Who Should Do Assessment and Make the Decisions? Transparency 5 - Tests Don't Make Decisions – People Do!!	A major principle, new to many professionals, is that parents should (it's the law!) and can be full partners in the assessment process – from start to finish.

Major Decisions in Early Intervention: 10 minutes	
Media/Materials	**Content and Learning Activities**
Transparencies 6 and 7 - What Decisions Does Assessment Help Us Make? (Overlay transparency #6 with #7) Transparency 8 - Linking Assessment-Intervention Goals	Assessment is crucial in helping us in 5 major ways: • screening • eligibility • program placement and planning • tracking progress • evaluating program impact Although separate decisions, professionals should recognize that these are interlocking or "linked" decisions.

Infants and Toddlers with Special Needs and Their Families

Content of Assessment Materials: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparencies 9 and 10 - What Factors Are Assessed?	Discuss the four kinds of assessment content: • developmental milestones (basis for most current scales) • functional competence (especially important for some children who may not show typical milestones) • atypical behavior (especially crucial to assess when delay, per se, is not the issue. Scales may soon be available, but now observation, judgment used) • child context (new materials help appraise family, setting factors)

Conventional Assessment and the Problems: 15 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 11 - Why Can't We Use Conventional Assessment Practices? Transparency 12 - Features of Early Development Transparency 13 - Wrong Practices, Wrong Assessment Transparency 14 - The Child is Not at Fault!	Discuss how professionals have been required to use materials/procedures that don't work and distort information. *Standard, rigid* procedures and *global, insensitive* items are problems. *Typical* infants, toddlers and preschoolers present a challenge. *Special needs* makes assessment with rigid psychometric standards not sensible. Demonstrate how unreasonable demands create assessment issues that are blamed on the child!

Holistic Assessment: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 15 - The Whole Child is Greater Than the Sum of the Parts	Development and behavior can't be chopped up and assessed in isolation. Developmental areas are interrelated, and assessment must address the whole child.

Assessment Methods: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparencies 16 and 17 - What Assessment Methods Are Useful?	Quality assessment employs • multiple forms of information (observation, testing, interview) • gathered across at least two situations and time periods • several ways to capture information

Major Kinds of Materials: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 18 - What Types of Assessment Tools Are Most Helpful?	Professionals and parents now have several types of materials: • ecological surveys • norm-based (some new materials permit adaptations) • performance/portfolio • curriculum-based (most useful) (more details on each type follows; see especially CBA)

Ecological Information: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 19 - Ecological Materials	• Professionals now agree that learning and development result from the interaction of child and environmental factors. • An ecological view is essential, and we must gather information about the child-in-context.

Performance Assessment: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 19 - Performance Assessment	Parents and professionals who will be working with a child appreciates actual samples of child performance.

Norm-Based Assessment: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 20 -Norm-Based Assessment	• Point out basic premise of norm-referenced assessment (compares to norm group) • Obvious problems when child is not "standard" – related to previous material.

Curricular-Based Assessment: 15 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 21 - Curriculum-Based Assessment Transparency 22 - Close-Up of Curriculum-Based Assessment Transparency 23 -Danny's Curriculum Record	Discuss how CBA is "teaching to the test," but that is ideal when the "test" items are acceptable objectives. Emphasize features and uses of CBA • Use this to illustrate status in one area, but • Emphasize that child profile in several areas is typically produced.

Team Models for Assessment: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 24 - Team Models	Point out that, in reality, teams may not follow pure models
Transparency 25 - Early Intervention Team Models	Model for assessment may not be the same for decision-making as for intervention.

Arrangements or "Set-Ups" for Assessment: 10 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 26 - Arrangements	• many agencies use arena-style assessment • arena arrangement is efficient, nonredundant, but • concerns include child fatigue and single-session information
Transparency 27 - Play-Based Assessment	• natural, play circumstances • often used with arena approach

Eligibility: 10 minutes	
Media/Materials	**Content and Learning Activities**
Transparencies 28, 29, and 30 - Close-Up on Eligibility	• Emphasize the controversy and issues surrounding eligibility (i.e., availability of facilities, staff, and finances). • Public Law regulations have utility, but much interpretation and discussion is occurring across states and within the field. • Various criteria can be used, but discussion should rest on wide information and risk factors.

Program Planning and Progress Tracking: 10 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 31 - Close-Up on Program Planning and Monitoring	• Emphasize that assessment is best when it is used to plan and monitor worthwhile instructional objectives. • "Worthwhile" is discussed within the four standards below.

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Standards for Assessment in Early Intervention: 10 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 32 - What Are Four Recommended Standards for Assessment? Transparencies 33, 34, 35, and 36 - Assessment Standards Checklist Handout - Checklist for Assessment Standards	Define the four standards: • treatment validity (utility) • social validity (acceptability) • convergent validity (inclusiveness) • consensual validity (decision agreement) Use this to give close-up of concerns with each form of validity

Overview of Convergent Assessment: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 37 - Convergent Assessment for Early Intervention	As a form of summary, stress how quality decisions depend on *inclusive* information based on *multiple*: • measures (CBA, performance, NBA, eco) • domains (all areas of development and competence) • sources (parents and professionals) • settings (home, center, clinic) • occasions (more than one time) • purposes for assessment (several decisions)

Media/Materials	Content and Learning Activities
Recommended Practices: 5 minutes	
Transparency 38 - DEC Recommended Practices In Assessment Handout - Recommended Practices Transparency 39 - Checklist for Assessment Standards	Use this as a summary for session: • Point out that specific practices have a basis in one or more of the four standards. • Standards and specific practices reflect a respect for and reliance on the family. • many agencies use arena-style assessment • arena arrangement is efficient, nonredundant, but • concerns include child fatigue and single-session information • natural, play circumstances • often used with arena approach • Emphasize the controversy and issues surrounding eligibility (i.e., availability of facilities, staff, and finances. • Public Law regulations have utility, but much interpretation and discussion is occurring across states and within the field. • Various criteria can be used, but discussion should rest on wide information and risk factors. • Emphasize that assessment is best when it is used to plan and monitor worthwhile instructional objectives. • "Worthwhile" is discussed within the four standards below.

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INSTRUCTOR NOTES

The material on the following pages is keyed to the set of transparencies
and provides the following:

1. **Main Points** to emphasize and **Comments** that explain the main
    points.

2. **Suggested Discussion Topics/Activities** (these may be used for
    discussion or as participant evaluation items). While the sequence of
    materials is deliberate, topics may be resequenced and/or material
    deleted at the discretion of the instructor.

3. **Suggestions** for preparing to present this module:

    ● Scan the Instructor Notes and look at the corresponding
    transparencies. Write your own remarks/reminders on the Notes
    related to each Transparency.

    ● Read over the Suggested Discussion Topics (Section 5). Some
    topics are specific to a transparency but many are meant to
    stimulate discussion and to synthesize several points. This material
    may be used during your presentation or duplicated and provided
    to participants, or used to evaluate comprehension.

Transparency #1: Objectives

By the end of this module, the participant will be able to:

1.   State the basic definition of assessment for early intervention.

2.   Answer the question: Who should do assessment and make decisions, and why?

3.   Identify the major decisions that assessment helps us make.

4.   Describe the four major standards for assessment.

5.   Explain the major aspects of convergent assessment.

6.   List aspects of early development that confound definitive assessment and diagnosis.

7.   Describe issues and problems related to conventional assessment of infants and toddlers.

8.   Name several methods used to collect and record information.

9.   Explain norm, curriculum, performance, and ecological based assessment.

10.   Describe team models and arrangements.

11.   List advantages of curriculum-based assessment.

12.   State options for eligibility assessment.

Transparency #2: What is assessment for early intervention?

Main point: In the final analysis, assessment is decision-making, but must be based on a reasonable collection of information that is reliable and truly representative of infant/toddler functioning.

Comments:

• The word "assessment" comes from a Greek word, *assidere*, which means "to sit beside." Thus, "to assess" suggests that we sit with and get to know the child.

• Much conventional so-called assessment never allows professionals to really know the child or the child's real circumstances, or literally even to sit beside the child. When babies (or children of any age) are removed from their natural contexts and are observed, tested, and otherwise evaluated, *assessment* is not really taking place.

• To qualify as good practice, assessment procedures and materials must meet certain standards that heighten the authenticity of information–information that provides a strong basis for the important decisions that have to be made.

• *Reliable* information means that the observations or results gathered one day are not much different over the next day or so. This form of reliability is referred to as *stability* (or test-retest reliability) and is important if we are to regard information as acceptable. Obviously, children – especially infants – change rapidly so we don't expect our observations to be stable for long. But we should be able to demonstrate that test results and observations portray the child at that time. (Another kind of reliability, "interobserver reliability," is discussed later.)

Session Objectives:

This requires no comment; handout is also provided so that participants can refer to the objectives.

Transparency #3, 4, 5: Who should do the assessment and make the decisions?

Main point: Multiple observers, especially parents and others who really know the child, participate in collecting information and making decisions based on the collective information.

Comments:

● Another form of reliability relates to agreement among testers or observers (interobserver reliability).

● We feel more confident about our own impressions and testing results when someone else independently concurs with us.

● What do we do when not everyone agrees on child performance or status – when people actually report *different* facts, observations, and scores? Do we reject one set of observations or reports (e.g., parental views, when different from ours)? Must we decide who is right and who is wrong? To answer this, consider that children can be quite different in different situations. Because this is the case, it is quite possible that parents are accurately reporting their child's performance as it really is in the home setting. Professionals who see the child only briefly and in a clinic circumstance may be seeing other aspects of the child and not seeing capabilities or difficulties evidenced at home.

● "Who is right or wrong?" is not the right question. The real question is: How can we get the best picture of the child for purposes of making important decisions regarding the child? The answer is that good assessment draws on multiple sources and we need not insist on nor presume identical observations from varying settings or observers.

● *REMEMBER* – **"TESTS DON'T MAKE DECISIONS -- PEOPLE DO!"**

Transparency #6, 7: What decisions does assessment help us make?

Main point: Different decisions require different information. Greater detail and accuracy are needed beyond screening, and the procedures and materials for eligibility determination and intervention planning should meet different quality standards.

Comments:

● Screening refers to collecting basic information to decide if a child deserves a closer assessment. Observation, parent reports, and simple direct testing are typically used to decide if a child "deserves closer assessment" or "further assessment not indicated."

● Ideally, screening should detect children who, indeed, evidence need for early intervention based on full assessment. Often, however, screening is far from precise and many children detected as "may be a problem" show absolutely no problems when fully assessed. This kind of screening error (false positive) results in needless full assessment (and parent concern!).

● "False negatives" refers to the error of screening results that *fail* to detect the need for further assessment when more detailed assessment is, indeed, in order. This kind of error is more serious because it means that children with possible special needs are overlooked and denied the potential benefits of early intervention.

● Eligibility and program decisions are examined in greater detail in the next several overheads.

Transparency #8: Linking assessment-intervention goals

Main point: There are several reasons we do assessment, and each reason or phase includes different concerns and decisions. Screening devices and results cannot be used for eligibility or program planning decisions.

Comments:

● The materials, procedures, and decisions related to screening are distinct from assessment for linking assessment findings to program goals, or for program planning and progress monitoring. The progressive purposes for assessment involve increasing precision and decision-making.

Transparency #9: What factors are assessed?

Main point: Several dimensions of importance can be appraised and some may be more useful and appropriate than others, depending on the child.

Comments:

● *Developmental milestones* – child development experts have identified major "landmarks" or "milestones" for development and the ages that they are typically achieved. Walking, using single words, eating with a spoon, looking for a hidden object, etc. are examples of milestones. For years, experts have used normal milestones for gauging a child's development and progress. Most parents and teachers want to know if the child is "on schedule," "keeping up," and can do what he or she is "supposed" to do at a given age. Use of normal developmental milestones is not always possible or desirable. Some children, for example, may not have use of their legs and never be able to walk. Yet, these children may be able to get around in other ways, alternative to walking. When serious motor, sensory, or other problems exist, many professionals use functional assessment.

● **Functional competence** – getting across the room, eating, and letting others know what you mean are illustrations of competencies that do not specify *how* they are accomplished – just that they are. For many children, attainment of important functions is far more feasible and relevant than typical milestone achievement. Professionals who work with children who have more pronounced physical differences prefer to use functional assessment. "Developmental achievement or delay" is replaced with "functional achievement or delay." Often, critical functions are based on the competencies expected of children as they mature and encounter new demands. Together, professionals and parents can identify the "criteria of the next environment" and use these as goals and objectives for assessment and planning.

Transparency #10: What factors are assessed? (continued)

• **Atypical behavior** – sometimes the central problem is not developmental or functional delay – sometimes the *presence* of serious behaviors can thwart child progress. Biting oneself or others, headbanging, attention disorders, excessive fear, repeating one action over and over, etc., are examples of atypical behaviors. The frequency, intensity, or deviation of these behaviors may be well beyond normal and interfere with progress. Atypical behavior may result from drug exposure, head trauma, neurological disorders, or other causes. Autism and neurodevelopmental problems are two conditions that include atypical behaviors for diagnosis. Professionals need ways to assess and document the presence and extent of children's atypical behavior when delay, per se, is not the problem. (Currently, measurement and reporting of atypical behavior is often based on direct observation and clinical opinion. Standardized, norm-referenced acceptable materials are not widely available.)

• **Child context** – child progress depends on not just the child's characteristics, but also the child's environment. Development is the product of child x quality of the setting. Because we recognize the importance of the child's *opportunities for development*, we must appraise the physical and social circumstances. While not numerous, a number of new materials allow us to assess the *child-in-context* and to check or rate situational factors. Parent-child interactions, availability of toys, language models, and use of praise or other reinforcement are examples of important context qualities.

• A major problem with conventional assessment is the use of test items that examine the child out of context, away from familiar objects and situations. A child may "fail" the object permanence item on a standardized test: he/she may not try to find the little rabbit that the examiner covered with a handkerchief. That same child, however, may seek and find a toy hidden in a toy box – or find his father's keys after seeing them dropped in a shirt pocket. The presence of sensory, motor, and affective differences makes valid assessment and a much greater challenge.

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Transparency #11, 12: Why can't we use conventional assessment practices? Features of Early Development that Challenge Assessment

Main point: Standardized, school-age type testing doesn't work or is often wrong when applied to infants and young children.

Comments:

• Psychologists and others have been required to use certain materials and procedures that often don't make sense. Either by their training or existing policies, professionals use tests and procedures that are contrary to the needs and characteristics of youngsters.

• Infants, toddlers, and preschoolers are not easily assessed and their development is often uneven and rapidly changes.

• Many children will not do well when assessment is "decontextualized" when procedures cannot be adapted. Assessment for early intervention demands departure from the psychometric "objective" approaches and requires a flexible, developmentally appropriate model that harmonizes with the realities of young children and their needs.

• Children who cannot manipulate blocks or pegs, who can distinguish shapes, or who are not interested in the assessment materials will not score well compared to "standard" children. Assessing a child's intellectual functioning through test items that demand manipulation will penalize children with sensory-motor difficulties. Yet, standardized administration procedures cannot be "violated." We are often faced with a "Hell if we do, Hell if we don't" situation when forced to use standardized procedures.

Transparency #13, 14: Wrong practices, wrong assessment

Note: Transparency #17 should be discussed first, and then #18 can be overlayed *superimposed) on #17 to make the point that infants and young children are disadvantaged by conventional (school age) assessment circumstances.

Main point: Three major problems faced by those who try to assess infants and preschoolers are:

● The natural, typical characteristics of youngsters – the rapid changes, the starts and stops, ups and downs

● The professional frustration when forced to use tests and procedures that are contrary to infant/child typical behavior and that are confounded by child sensory, motor, and affective differences.

● Serious assessment problems arise when *standardized*, norm-referenced materials are forced on the child and person responsible for the assessment.

Comments:

Standardized - refers to fixed item content and procedures that were used with the sample of children employed in test construction.

Norm-referenced - refers to the scores or performance of the standardization sample

● When using standardized, norm-referenced instruments, the assessor must not deviate from standardized procedures. The logic seems obvious: you won't be able to compare the performance of the child being tested to the performance of the standardization group if you coach or otherwise alter the circumstances – "it wouldn't be fair" and the resulting scores cannot be interpreted with respect to the norms.

Transparency #13, 14: Wrong practices, wrong assessment (continued)

● But equally obvious is the dilemma produced by using items and procedures "unfair" to the child being assessed. Children with motor problems, for example, may not be able to point, stack blocks (apparently a favorite task on such tests), put pegs in holes, etc. When motor-dependent items are used to assess motor skills, that is one thing – but often motor dependent tasks are used to assess intellectual functioning. Obviously, a child with sensory or motor problems will be at a real disadvantage when tested with most conventional "intelligence" tests.

What's an assessor to do? If you change the administration, you violate norms and cannot use the normative frame of reference. If you do not adapt the items and procedures and "use common sense," the scores on cognitive, language, and even social dimensions will be erroneous.

● Fortunately, some new standardized materials address adaptations and actually include instructions to alter the material. Further, many psychologists and others who do assessments are demanding the right to use or not use instruments, and to use their clinical judgments in selecting materials. (These demands result from situations where certain instruments are mandated for use, even though the requirement to use such materials might be clearly misguided.)

● The solution is to employ a set of varied materials, to rely on pooled judgment, and to understand that norm-referencing is of limited value with many infants.

Transparency #15: The whole child is greater than the sum of the parts

Main point: It is important to realize that the separate developmental domains were invented by professionals to help classify skills and problems. In reality, skill development is rarely in one "domain."

Comments:

● Assessment *must* include appraisal across all areas to provide *inclusive information* that will assist in more accurate and useful decision-making.

Consider language – certainly language development depends on motor, social, and cognitive factors. A child (e.g., who has motor restrictions) may very well experience reduced language, social, and intellectual opportunities. All the "separate" developmental areas are very interdependent.

Transparency #16, 17: What assessment methods are useful?

Main point: Full assessment includes multiple methods for gathering information.

Comments:

• Although *testing* is a convenient and traditional approach, much information is neglected, distorted, or not available through testing only.

• Actual *observation* in natural situations (home, infant center, etc.) is an excellent way to appraise real functioning in real situations – information that can be supplement or challenge test results.

• *Interviews* of parents and others who are familiar with the child may be better sources of information than busy professionals who may only see the child for a very brief period. Of course, professionals do have the advantage of training and skills in assessment. Both professional and parent information are important and compliment each other.

• Most people know that children (and adults) will perform differently in their natural situations than in a clinic. Child behavior elicited by strange adults in strange situations will most probably not provide a good picture (won't be valid) of how that child functions "for real."

• When assessment is done at the agency setting or clinic, simulated home circumstances and family/child-friendly arrangements help to enhance the assessment.

• There are three *times* for gathering information: (a) the *immediate* functioning of the infant/child during testing or observation; (b) how the infant/child is currently functioning, as revealed by interviews or observations over an interval of several weeks (*present* performance); and (c) how the child has been behaving over the past months or years as related through retrospective reports from parents or others.

Transparency #16, 17: What assessment methods are useful? (continued)

● Information can be gathered through direct observation and recording of the frequency, duration, intensity, etc. If child behavior tantrums, sleep problems, use of words, etc. can all be observed and recorded.

● Checklists are a particularly useful and convenient method for gathering important information. Many checklists are available for estimating developmental progress or delay, for gauging behavior disorders, and for recording a variety of other important behaviors and characteristics.

● Everybody is familiar with rating scales. Parents as well as professionals can rate their impressions or observations of problems, needs, degree of progress, etc. Many useful rating scales are available for home, infant center, or preschool use.

Transparency #18: What types of assessment tools are helpful?

Main point: Although there are several types of assessment tools. No *one* tool provides the whole picture of the child.

Comments:

● Several main types of tools should be used to provide inclusive information.

● Four of the best tools are ecological appraisals, performance assessment, norm-based, and especially curriculum-based assessment.

Transparency #19: Ecological appraisals

Main point: Most professionals now recognize that development and behavior result from the child interacting with the environment. The quality of development to a large extent depends on the qualities of the environment. For most children, the important parts of the environment include the home situation, parenting skills, and the infant/child care program.

Comments:

● Information regarding the child's context – or "ecology" – can be gained through interviews, checklists, and observation. Detecting the needs and resources of the family is of major importance, and is needed for interpreting other child information.

● Other factors that can be estimated include physical (room layout, materials available, lighting, temperature control, and the properties of toys) and social (extent of peer interaction, caregiver sensitivity and responsiveness, daily routines, and provision of rewards and punishment). (This topic is not detailed here and reference should be made to other family modules.)

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Transparency #19: Performance assessment

This assessment focuses on how the child performs in his/her actual life circumstances. The central idea is to look at the child's functioning in context.

● Advocates of performance or "authentic" assessment argue against "de-contextualized assessment." Much conventional "objective testing" involves assessing unrelated skills in unfamiliar situations. Child functioning will be optimum in the situations where behavior is learned and practiced.

● Work samples, snap-shots, audio and video tapes, anecdotes, and other materials can be assembled into a *portfolio* that depicts the child. As additions are made to the portfolio, changes in child performance and characteristics can be documented.

● Note that portfolio assessment does not provide normative comparisons, but is useful to teachers and others who help to plan child programs. Parents especially appreciate seeing and reviewing their child's portfolio of accomplishment.

Transparency #20: Norm-based assessment

Main point: Often, it is helpful to compare a child to others of the same age. Parents especially may ask how their child compares to "normal" children. Norm-based or "norm referenced" assessment is intended to permit us to make comparisons, and sometimes these comparisons are required to secure special services for a child (see transparency and notes on eligibility).

Comments:

• Unfortunately, it is often not possible to use norm referenced materials with the very children we need to assess. The "standard" or "reference" groups used by test developers traditionally have not included children with special needs. Items on most of these norm referenced tests are designed for children with typical vision, hearing, dexterity, emotional behavior, etc. When children have sensory and motor differences, it is not really sensible to estimate understanding, comprehension, intelligence, etc. with test items that depend on seeing, hearing, or manipulating. For example, to discover if a child knows big versus small, square or circle, first versus last, on versus under, etc., test items that demand sorting or pointing will not be feasible for children who have trouble using their hands – even though they know the concepts being tested.

• Likewise, children who don't sit still or "comply" may perform below what they could under different circumstances. Many children from cultures not represented in the norm groups will also be at a disadvantage.

• To accommodate differences, the sensible thing to do would be to alter the test item or how it is presented. Instead of "point to," you might, for example, ask the child to say "yes" or to nod when you point to the "big" one (assuming the child can see).

Transparency #20: Norm-based assessment (continued)

● Although adapting items is useful, most conventional norm referenced tools do not allow us to depart from *standard* procedures. Special coaching or other arrangements destroy the basis for making comparisons with children who performed under strictly standard conditions.

● Use of conventional norm referenced tools, then, often produces a dilemma: use them as intended and get distorted information – or adapt the content and administration and be unable to make comparisons (the reason for norm based assessment)!

● Fortunately, new assessment materials are becoming available that (a) include children from differing cultures and with special needs, and (b) provide for alternative items and administration to accommodate differences.

● Finally, certain new norm referenced materials rely on parent interviews and observation of children in their own situations. These new materials are much better to use and give us a way to make comparisons with same age children.

Transparency #21, 22, 23: Curriculum-based assessment (CBA)/Close-up

Main point: CBA is the most useful and acceptable form of assessment for parents and professionals. This kind of assessment uses a curriculum suitable to the child's age and special needs. A curriculum is a set of objectives and methods for teaching, and many different curricula are available. Some curricula are suited to children with mild delays, while others are designed for children with severe problems in vision, hearing, fine and gross motor functioning, cognition, language development, or socioemotional behavior.

Comments:

• A curriculum can include a scale keyed to its own objectives (i.e., a scale that allows us to check off child mastery of objectives). As we observe or otherwise gather information, we can estimate where the child is in language, social/emotional, motor, and/or cognitive development. All sorts of adaptations are permitted when using a CBA scale. Instead of rigid administration and item content, the assessor is free to vary circumstances with the goal of finding out if a child can accomplish an objective, given certain changes or help. The information we get from CBA lets us know what a child *can* do.

• There are even CBA scales that are not tied to a particular curriculum, but that relate to many similar curricula. Use of these "generic" CBA materials can be very helpful, especially when the child is not currently enrolled in a specific program curriculum. (Some curricula also have estimated norms that make possible developmental comparisons, thus approximating norm-referenced assessment.)

• CBA produces information *before*, *during*, and *after* program efforts. A *before* measure is important for estimating program entry points and feasible instructional objectives. Many CBA scales allow scoring of skills as full mastery, partial or emerging, or absent.

• *During* intervention, tracking the child's progress within the curriculum provides feedback for refining objectives and methods. Some curricula include charts or graphs that are good ways to display progress. This formative information is valuable to share with parents.

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Transparency #21, 22, 23: Curriculum-based assessment (CBA)/Close-up (continued)

● *After* a period of time (e.g., 6 months or before transition to another program), progress can be summarized by showing the child's entry and exit levels in the curriculum.

● Team members (e.g., physical therapists, speech/language pathologists, psychologists) often use specific and different assessment devices. A good CBA scale can be used by *all* professionals and, thus, provides a common tool to enhance team decision-making.

● Finally, parents can have a strong role in CBA. Many of the items on CBA scales can be best answered by parents (e.g., "Does ___ share a favorite toy?"). Involving parents is also important to obtain their perceptions and concerns. Even when parent estimates of child capabilities differ from professional estimates, such information is important and may lead to greater insights.

● Parents are a rich source of information and CBA invites full parent participation, either at the agency or in the home.

Transparency #24, 25: Team models

Main point: Teams are groups of individuals who work together toward common missions. Although three types of teams are usually identified, in practice teams often function differently depending on the job to be done. For example, teams may practice multidisciplinary assessment but transdisciplinary intervention.

Comments:

● Usually one member is responsible for assembling the various, sometimes conflicting, reports. This approach is not consistent with our view of the "whole child" and often produces reports that contain conflicting results and recommendations.

Multidisciplinary (MDT). Separate professionals, separate assessments, and separate reports characterize this mode of operation. Hospitals, medical clinics, and much of public education practice this model – sometimes referred to as a "factory" or assembly-line model.

Interdisciplinary (IDT). In this approach, team members consult with each other and coordinate assessment. Members may borrow information from each other, and even substitute for each other. Common goals and concerns are established and assessment is much more coordinated and less fractured than with MDT.

Each team member, however, is responsible for summarizing assessment in his/her respective developmental area (physical therapist, motor area; psychologist, intellectual/social; speech-language pathologist, language). Reports typically include a common introduction, background, summaries by developmental areas (rather than by test names), and a summary written by the team coordinator, who attempts to integrate and reconcile assessment information.

Transparency #24, 25: Team models (continued)

Transdisciplinary (TDT). Releasing "ownership" of "professional turf" and sharing roles and responsibilities characterize this approach.

Professionals who get to know each other and learn enough about each other's areas can work as a real mutual team.

Common goals, common – instead of redundant – assessment activities, and integrated findings are possible with this approach. Children don't have to stack blocks, for example, for the psychologist and the physical therapist; instead, both professionals observe the child at the same time and note relevant findings.

Often, the parent is central in this approach, typically used in arena assessment. Often, also, services are integrated and intervention recommendations are carried out by one member who acts as a generalist.

● In practice, combinations and permutations of the three models are employed. Both transdisciplinary and interdisciplinary teams are preferred over multidisciplinary teams

Transparency #26, 27: Arrangements-arena style and play-based assessment

Main point: "Arena assessment" simply means that a team "surrounds" the child during assessment. Often, the parent (mother) is the primary person who handles the baby, taking instructions or coaching from professionals on the side-lines.

Comments:

● Arena assessment is efficient -- everything takes place in the same setting and at the same time. Observations and interpretations are shared in an ongoing fashion and each team member requests and considers issues as they arise. The arena session lends itself to the use curriculum-based assessment where the team members can check off skills as they see them. It is also efficient for the parents – they don't have to schedule separate meetings and meet with new professionals repeatedly.

● There are a few possible problems with arena assessment, however. The session may be too long. The child as well as the parent may feel awkward or intimidated, being the center of attention. Finally, arena procedures do not promote *independent* observations and evaluations. The ongoing collaboration during assessment produces a convergence of opinion, making comparisons and independent observers not possible.

● Play is a natural activity that can be used to assess most skills. Having the caregiver play with and otherwise get the child "to perform" is especially helpful during arena style assessment.

Transparency #28, 29, 30: Close-up on eligibility

Main point: Assessment for eligibility creates the most controversy. Because special services can get expensive, assessment has to show that the infant or child, indeed, is in need of special intervention to prevent or offset developmental problems.

Comments:

• Most regulations emphasize assessment to document how *different* a child is compared to typical children. Basically, there are three ways to assess delay or deviation from typical:

- Percent delay (e.g., language is 50% of expected for age).

- Standard deviation (e.g., minus 1 SD in language; i.e., performance is at or below 84% of same age children). (Most instruments are standardized with a mean of 100 and SD of 15. Within a normal distribution, half of the scores are above 100, half below. One SD takes in about 34% of the distribution; thus, performance one SD *below* the mean equals a standing of 50% + 34% = 84% of others who have done better.)

- Clinical judgment (e.g., when standardized, norm referenced tools are not feasible, the collective judgment of professionals can be used to declare eligibility.)

Another major way to get access to early intervention services is to identify a recognized syndrome that has "automatic" eligibility. Diagnosis chromosomal abnormalities (e.g., Down syndrome, Tay Sack), and certain other conditions with *established risk* will yield eligibility.

Transparency #28, 29, 30: Close-up on eligibility (continued)

• Professionals may argue that child/family circumstances present substantial risk for *potential* delay or defect. Criteria for eligibility based on environmental and/or maternal risk factors are less definitive, and at state discretion. Many professionals are working to develop clear criteria and standards for declaring eligibility based on apparent risk. After all, a mission of early intervention is to *prevent* developmental problems and delay. In the final analysis, it is clear that eligibility cannot be based on a score, per se, but must be founded on a collection of information that truly depicts the child and circumstances that contribute to or thwart development.

• Because of all the issues related to diagnosis at such an early age, many professionals are advocating for a new, broader category for eligibility (i.e., "delayed diagnosis"). A *delayed diagnosis* would provide eligibility until the infant reaches age 3 or older when a more definitive assessment might be made.

Transparency #31: Close up on program planning and monitoring

Main point: Planning the child's program and tracking progress are two important assessment activities.

Comments:

• (Because Curriculum-Based Assessment is ideal for planning and tracking, refer to the notes regarding CBA.)

• See suggested topics/activities.

Transparency #32, 33, 34, 35, 36, 37: What are four recommended standards for assessment?

Main point: Four themes or dimensions characterize assessment for infants: it is useful, acceptable, inclusive, and consensual. (The overheads are somewhat self-explanatory.)

Comments:

● **Treatment validity** is also referred to as utility. We can ask how useful assessment is for identifying child goals, for selecting methods, and for evaluating change.

● **Social validity** is also referred to as acceptability. We can judge how worthwhile the goals are identified through assessment. Likewise, we can judge the acceptability of the methods and social significance of change detected by assessment. Often assessment scores show change that is of little social significance (e.g., IQ change of a few points). Similarly, sometimes assessment fails to be sensitive enough to detect changes of real importance to parents and others.

● **Convergent validity** refers to the inclusiveness of information, and how generalizable the findings are. It is especially important to use several kinds of tools, collect information across several sources and settings, and on more than one occasion.

(see Transparency #37)

● **Consensual validity** refers to the degree to which assessment-based decisions have been reached through collaborative negotiated means.

Transparency #38: Examples of Recommended Practices

Main point: These are selected examples of specific practices that are consistent with the four standards.

Comments:

● All the specific practices were developed by professionals and parents.

● These examples are published by the Division on Early Childhood, The Council for Exceptional Children (see Resources).

● Refer to Checklist for Assessment Standards (transparency #39).

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Transparency #39: Checklist for Assessment Standards

Main point: This checklist can be used to evaluate assessment practices within an agency, etc.

Comments:

• These criteria can be used to appraise a specific assessment instrument or practice.

• This checklist can be shared with other professionals who are responsible for assessment.

• Some teachers and others may want to use this checklist as a guide to give school psychologists, speech-language pathologists, etc., a set of desirable criteria for acceptable assessment procedures.

SUGGESTED DISCUSSION TOPICS

The following discussion topics may be used to expand the time and scope of this module. Some of the topics may be assigned as "homework," used for small group discussion, or selectively used to maintain audience interest and involvement. The list or portions of it may be copied, distributed, and used as thought questions, assignments, or to evaluate understanding of the module material.

NOTE: Many of these discussion topics cut across or synthesize material presented in two or more transparencies, while other topics relate to specific transparencies.

What is the difference between testing and assessment?

Why is assessment defined as "decision-making?"

Discuss the pros and cons of relying on parents for assessment information.

Why should we involve parents in assessment, despite arguments against this?

****

What is screening and what can it do and not do?

When might the use of developmental milestones NOT be an appropriate basis for assessing a child?

Discuss how identifying the demands of the child's next probable environment might be useful.

How can the presence of atypical behaviors become a major developmental problem?

What aspects of the child's home situation might be important to know about?

List the demands expected of *parents* as they become caregivers.

Try listing the capabilities possibly expected of a toddler entering a center program.

List the capabilities typically expected of a preschooler entering a kindergarten program.

Make a list of infant and toddler *atypical* behaviors that can cause trouble and obstruct development.

Identify problems and issues with traditional assessment practices.

What is there about infants and toddlers that confounds usual assessment practices?

Why is standardized assessment an "unnatural approach" to assessment with infants and preschoolers with special needs?

Relate personal "war stories" about how children have been mis-assessed or assessed with the wrong procedures and materials.

* * * * * * * * *

Report your views concerning norm-referenced measures. Are these measures useful? Are they fair?

Is anyone using portfolio assessment? Discuss what it is and its value.

Is anyone using a specific curriculum and its assessment materials? Discuss the advantages of CBA.

Based on transparency of "Danny's Curriculum Record," State Danny's approximate "developmental age"

Identify what curricular objectives would be the next likely instructional objectives. Note: Usually those scored as + - are best to select for instruction because they are emerging/partial and will most likely present a *reasonable challenge.*

Identify typical problems in team decision making. List problems such as some of the following:

- Inexperience in group dynamics
- Lack of structure and mission
- Absent leadership or facilitation
- Strong professional boundaries and jargon
- Unequal member influence
- Perfunctory parent participation
- Little collaboration
- Decisions by fiat non consensus
- Preconceived views about child and family
- Disparate data unresolved
- No common assessment tools
- No ecological data
- Limited exposure to child and family
- Emphasis on diagnosis/IQ versus service delivery

Why are multidisciplinary teams not recommended in early intervention?

What are other team models and how do they differ?

Concerning arena assessment, list advantages/disadvantages from the child's perspective.

Can a child's own toys and familiar objects be used in assessment?

Is anyone familiar with play-based assessment? What are the advantages of this approach?

Describe eligibility criteria in your state. (If the criteria are not known, this can be an assignment.)

Why is "developmental delay" a problem? Consider 6-month delay for a 3-year-old versus a 6-month delay for a 1-year-old.

Discuss the three major eligibility standards:

- assessed delay
- diagnosed (established risk) condition
- at risk (biological or environmental)

Use "Danny's Curriculum Record" again to illustrate progress monitoring. Place +s next to objectives mastered over (e.g., a one-year intervention program). Show how such a record is easy to keep and appreciated by parents.

Name and describe the four kinds of validities (standards).

What is the difference between *utility* and *acceptability*?

Convergent validity refers to use of inclusive information; name the several aspects of convergent assessment.

Why is it important for professionals and parents to reach agreement about assessment decisions?

Are there any recommended practices that do not seem feasible or acceptable? Any important practices missing?

Discuss how a given specific practice reflects one or more of the recommended four standards for assessment.

RESOURCE LIST

A few major references are listed below. These chapters or articles will provide greater detail and further topics in the area of early intervention assessment.

Newsletters

Zero to Three - published six times per year by the National Center for Clinical Infant Programs, PO Box 25494, Richmond, VA 23260-5494 (Federal ID 52-1105189). Contributing authors come from a wide range of disciplines to share their information regarding infant and young child development, best practices in early intervention, and issues in early childhood education. Reviews of recent publications and videotapes are also included.

DEC Communicator - published four times a year by the Division for Early Childhood, The Council for Exceptional Children – through Sarah Rule, Editor, Center for Persons with Disabilities, Utah State University, Logan, UT 84322-6805. Included in each issue are news from state and local chapters, information regarding current and future projects, position announcements, and information describing personnel preparation programs.

Books

Cohen, L. G., & Spenciner, L. J. (1994). *Assessment of young children.* New York: Longman.

> This book is one of the single best sources for an understanding of the importance of appropriate practices of assessment in early intervention. The book provides the reader with a basic understanding of the assessment process, skills to use during assessment and demonstrate how the results of assessment are linked to planning for instruction. Chapters are devoted to measuring child's performance, the importance of family involvement in the process, the use of screening and assessment instruments, and assessment of children with specific domain disabilities.

Bagnato, S. J., & Neisworth, J. T. (1991). *Assessment for early intervention: Best practices for professionals*. New York: Guilford Press.

Part of the Guilford School Practitioner Series clearly addressed to the practice of assessment with preschoolers. The contents include topics of great current concern and reflect the emerging recommended practices of professional organizations, such as the DEC, NASP, and NAEYC. The book describes principles, materials, and practices in harmony with a family-centered, developmentally appropriate approach to assessment.

Bryant, D. M., & Graham, M. A. (Eds.). (1993). *Implementing early intervention: From research to effective practice*. New York: Guilford Press.

As the authors point out in their Preface, this book examines the concept of early intervention from a theoretical standpoint, including an evolution of early intervention and an in-depth discussion of the issues surrounding the definitions of early intervention, eligibility, utilization of services, and effective screening methods. Special emphasis is placed upon Part H of Public Law 99-457, including the guidelines for services, budgetary concerns, and policy issues; and the best practice guidelines for screening, assessment, and linkage of results to early intervention programming.

Linder, T. W. (1993). *Transdisciplinary play-based assessment: A functional approach to working with young children* (rev. ed.). Baltimore: Brookes.

The transdisciplinary play-based assessment model capitalizes on what children do best – play. This model shows great promise for use in early intervention/special education settings, by allowing an individual, comprehensive look at the "whole" child through the collective observation of all team members – including the child's parents. The easy-to-use book contains observation guidelines and worksheets for assessing a child's development in the cognitive, social-emotional, communication and language, and sensorimotor domains. Based upon these observations, team members can identify a child's strengths, needs, and concerns in each area of development and implement appropriate intervention programs.

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Benner, S. M. (1992). *Assessing young children with special needs: An ecological perspective.* New York: Longman.

This text presents an ecological perspective of assessment of young children with special needs. The organization of the book is in four parts. Part 1 outlines the theoretical background for and stages of ecological assessments. Part 2 focuses on family and environmental issues, including family strengths and the home environment. Part 3 addresses the validity of this model and encourages examiners to use this approach with children having diverse cultural and linguistic backgrounds. Also covered are assessment procedures for each of the developmental domains. Part 4 discusses child assessment and how it relates to program evaluation and emerging issues in early childhood, such as AIDS, and advancing medical technology.

Journals

Topics in Early Childhood Special Education (TECSE) - published quarterly by PRO-ED, 8700 Shoal Creek Boulevard, Austin, TX 78757-6897 (ISSN 0271-1214) (USPS 770-010). Published to communicate information about early intervention. Articles address personnel preparation, policy issues, and operation of intervention programs. The intent of the journal is to publish information that will improve the lives of young children and their families.

Journal of Early Intervention (formerly Journal of the Division for Early Childhood) - published four times a year by the Division for Early Childhood, The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091 (SSN 1053-8151). Articles are related to research and practice in early intervention for infants and young children with special needs and their families. Because families assume a central role in intervention programs, articles that relate to family functioning, adaptation, and needs as they relate to the development of the child with special needs are incorporated into this journal. Articles address intervention for minority and culturally diverse children and their families. Research methodologies and classroom practices are also included.

Infants and Young Children: An Interdisciplinary Journal of Special Care Practices - published four times a year by Aspen Publishers, 7201 McKinney Circle, Frederick, MD 21701 (ISSN 0896-3746). Devoted to the clinical management of infants and young children (birth to 3 years) and their families with or at-risk for developmental disabilities. It is interdisciplinary and is designed to provide up-to-date information regarding the application of health care; educational, therapeutic, diagnostic, and family support principles and concepts to practice settings. Articles synthesize theory, consensus, and controversy in order to suggest specific actions.

Young Children - published by the National Association for the Education of Young Children. Peer-reviewed articles of research and practice in general early childhood education is the focus of this journal. It emphasizes practical application of child development theory and research. Inclusive preschool education is frequently discussed in the journal.

Manuals

DEC Recommended Practices: Indicators of Quality In Programs for Infants and Young Children with Special Needs and Their Families - published by The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091 (ISBN 0-86586-234-6) (Stock Number D417). The purpose of this document is to describe a set of indicators that DEC recommends for early intervention and early childhood special education programs for infants and young children with special needs and their families. The criteria for these indicators include research bases, family centered, multicultural emphasis, cross-disciplinary participation, developmentally/chronologically age-appropriate, and normalization. Professionals may use them to examine the practices they currently employ in their programs, and to guide the selection practices for new programs. Families may use them as a "consumer" guide when selecting a program for their child with special needs.

PARTICIPANT HANDOUTS

Handout 1: Session Objectives

Handout 2: Danny's Curriculum Record

Handout 3: Checklist for Assessment Standards

Handout 4: Selected DEC Recommended Practices on Assessment

Handout 5: DEC Recommended Practices on Assessment

ASSESSMENT
FOR
EARLY INTERVENTION

Assessment for Early Intervention: New Purposes, New Practices

OBJECTIVES

By the end of this module, the participant will be able to:

1. State the basic definition of assessment for early intervention.

2. Answer the question: Who should do assessment and make decisions, and why?

3. Identify the major decisions that assessment helps us make.

4. Describe four major factors or dimensions that are assessed.

5. List aspects of early development that confound definitive assessment and diagnosis.

6. Describe issues and problems related to conventional assessment of infants and toddlers.

7. Name several methods used to collect and record information.

8. Explain norm, curriculum, performance, and ecological based assessment.

9. List advantages of curriculum-based assessment.

10. Describe team models and arrangements for assessment.

11. State options for eligibility assessment.

12. Explain how curriculum-based assessment is ideal for program planning and monitoring.

13. Describe the four major standards for assessment.

14. Describe the strength of "convergent assessment."

15. State how the specific Recommended Practices are consistent with a family centered approach.

#1

WHAT IS ASSESSMENT ?

Assessment for Early Intervention is . . .

decision-making based on systemmatic
inclusive, reliable information

*decision-making, systemmatic,
inclusive, reliable*

• WHO SHOULD DO ASSESSMENT AND MAKE THE DECISIONS?

Parents, family members, and professionals all contribute to the assessment process and decision-making.

Parents

provide invaluable information not otherwise available through their

- verbal reports
- ratings of the child's & family's strengths & needs

#3

• WHO SHOULD DO ASSESSMENT AND MAKE THE DECISIONS?
(continued)

Professionals

- conduct interviews
- do systematic observations
- do formal and informal assessment
- work with parents to collect child information

#4
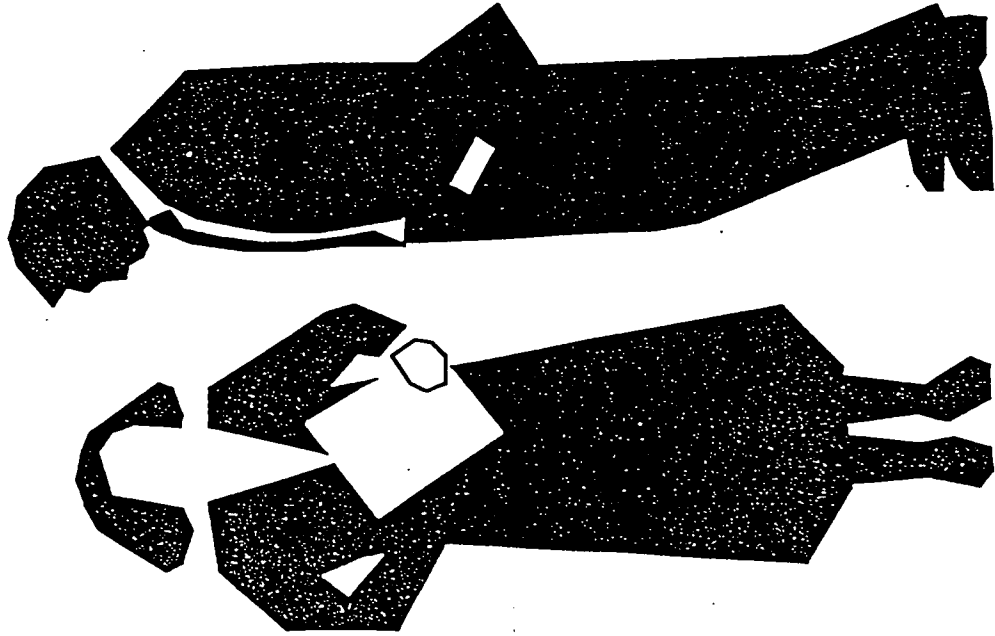
Tests Don't Make Decisions – People Do!

• WHAT DECISIONS DOES ASSESSMENT HELP US MAKE?

- Should infants and toddlers be provided with detailed assessment?

- Who qualifies for early intervention services?

- What are appropriate goals, objectives, and services?

- Should ongoing program services and objectives be changed?

- Is the program effective, efficient, and acceptable?

#6

Screening

Eligibility

Program
Planning

Program
Monitoring

Program
Evaluation

#7

Linking Assessment - Intervention Goals

Screen / Identify

Assess / Link

Program / Intervene

Evaluate / Monitor
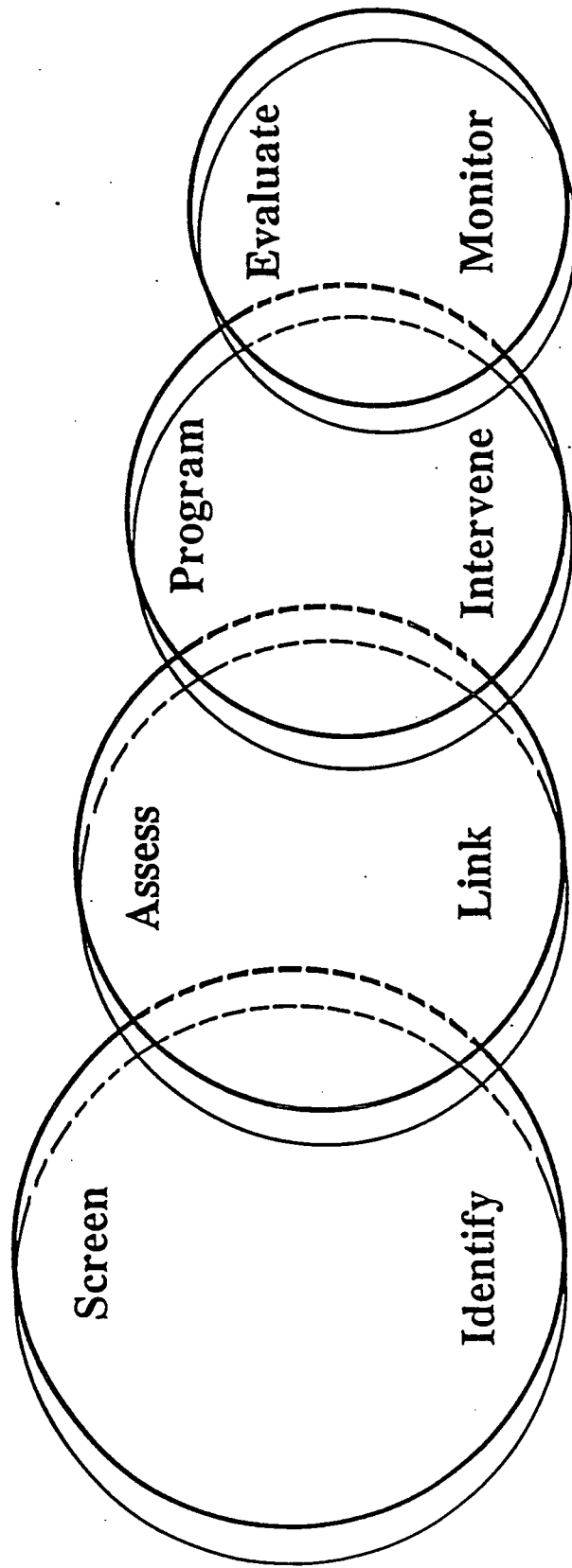
Broad-Spectrum Analysis

Narrow-Spectrum Analysis

Time

265

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WHAT FACTORS ARE ASSESSED?

- Developmental Milestones
  attainment, delay

- Walks at about 12 months

- Begins to use single words at about
  24 months

- Functional Competence
  esp., important life skills to meet
  demands of present and next
  environment

- Gets across room

- Communicates wants to other people

#9

• WHAT FACTORS ARE ASSESSED?
(continued)

• Atypical Behavior
e.g., self-injury, attachment disorders, neurodevelopmental problems

• Failure to bond with mother

• Too easily startled, has seizures

• Child Context
e.g., family strengths and needs, qualities of child care context

• Multiple caregivers present

• Signal-to-noise ratio is poor

#10

WHY CAN'T WE USE CONVENTIONAL ASSESSMENT PRACTICES?

"Conventional"--one-shot formal testing with standardized items, objects, and procedures not suited to the child.

✔ *Misleading*

✔ *Usually global, rather than specific*

✔ *Not related to services*

✔ *Insensitive to child changes*

Problems with conventional practices

- *Typical Early Development versus Conventional Assessment*

- *Assessment Circumstances Versus Child Characteristics*

#11

FEATURES OF EARLY DEVELOPMENT THAT CHALLENGE ASSESSMENT

- Noncontinuous progress, "spurts" in development

- Often strong individual starts, delays, and patterns

- Fluctuation at developmental transitions

- Uneven progress across developmental domains

#12

WRONG PRACTICES, WRONG ASSESSMENT

ASSESSMENT/ ASSESSOR	
• Unfamiliar surroundings	
• Strange adults	
• Boring tasks	
• Low interest objects	
• Protracted session	
• Developmentally inappropriate procedures	
• Sensory response demands not adapted to child	

The younger the child, the less possible to diagnose, label, and predict

#13

	CHILD
	• Attention deficits
	• Hyperactivity
	• Poor motivation
	• Little endurance
	• Low frustration tolerance
	• Oppositional, noncompliant syndrome
	• And is "untestable!"

The child is not at fault!

#14

Language   Social

Cognitive   Motor

The Whole Child is
Greater Than the
Sum of the Parts

#15

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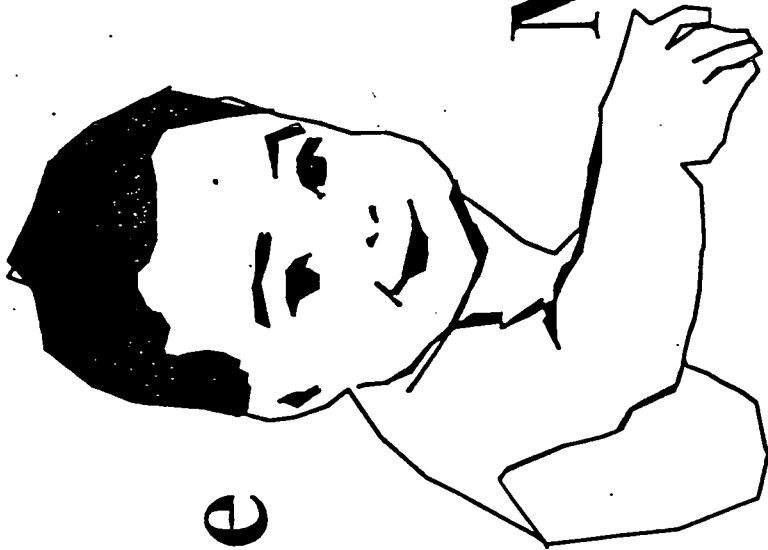
• WHAT ASSESSMENT METHODS ARE USEFUL?

❑ We rely on . . .
- observation
- testing
- interviews/reports

❑ Based on . . .
- natural contexts
- clinic setting
- immediate, present, past behavior

#16

- **WHAT ASSESSMENT METHODS ARE USEFUL?** (continued)

❏ Record information with . . .
- direct recording (frequency, latency, duration, etc.)
- checklists (+, ±, -)
- ratings (1, 2, 3, 4, 5)
- written commentary or audio-photo samples

#17

• WHAT TYPES OF ASSESSMENT TOOLS ARE MOST HELPFUL?

- Many kinds of materials are available

- For inclusive and complimentary information, use . . .

  - ❑ Ecological Appraisals

  - ❑ Performance Assessment

  - ❑ Norm-Based Assessment

  - ❑ Curriculum-Based Assessment

#18

❑ Ecological Appraisals (Eco-Based)
   Collect information regarding
   family and home context:
   - interviews
   - checklists on needs and resources
   - parent-child dynamics

❑ Performance-Based Assessment
   (PBA)
   Document progress with
   - work samples over time
   - photos, videos
   - portfolio or resume

#19

❑ Norm-Based Assessment (NBA)

Compare child's functioning to:

- reference or normative group that . . .

  - is same age
  - has "similar" characteristics
  - was used to standardized materials and procedures
  - permits adapting procedures to child's
  - sensory and response capabilities

#20

❑ Curriculum-Based Assessment
(CBA)

Compare child's functioning to:
- a set of curriculum objectives
  that...

  - includes sequences of
    objectives
  - typically includes teaching
    objectives in

    -communication
    -cognitive
    -social-emotional
    -motor

#21

CLOSE-UP OF CURRICULUM-BASED ASSESSMENT (CBA)

- Identifies skills that are ABSENT, EMERGING, PRESENT

- Mutual approach and tool for assessment team

- Informal, adaptive, uses child's natural setting

- Finds entry skills and detects progress

- Many CBA scales available

- Most useful for program planning, tracking, evaluation

- Promotes consensus

#22

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DANNY'S CURRICULUM RECORD

Item Number	DEVELOPMENTAL LEVELS AND ITEMS	DATE	DATE	DATE	DATE
	12-15 months DA = 18.6 months DQ = 62				
22	Turns page of cardboard book		+		
23	Removes cover from small square box		+		
24	Places one or two pegs in pegboard		+		
25	Builds two-cube tower		+		
26	Scribbles spontaneously (no demonstration		+		
27	Releases raisin into small bottle		+		
	16-19 months				
28	Places six pegs in pegboard without help		+		
29	Builds three-cube tower		+		
30	Places round form in formboard (three forms presented)		+		
31	Imitates crayon stroke		±		
	20-23 months				
32	Places six pegs in pegboard in 34 seconds		-		
33	Makes vertical and circular scribble after demonstration		-		
34	Completes three-piece formboard		-		
35	Builds six-cube tower		-		
36	Holds crayon with fingers		±		
37	Attempts to fold paper imitatively		-		
	24-27 months				
38	Draws vertical and horizontal strokes imitatively				
39	Completes reversed formboard				
40	Aligns two or more cubes for train, no smokestack				
41	Unscrews jar lid				
42	Scribbles with circular motion				

#23

TEAM MODELS

- Multidisciplinary

- independent, separate appraisals
- "assembly line" approach
- redundant tasks, efforts
- multiple appointments, locations

- Interdisciplinary

- some sharing between two professionals
- good balance between separate and shared expertise
- feasible after some co-training

- Transdisciplinary

- considerable professional role-sharing
- efficient, collaborative
- requires professional closeness, similarity of skills

#24

Early Intervention Team Models

Multidisciplinary   **Interdisciplinary**   **Transdisciplinary**

Assessment

Decision-making

Intervention with Child

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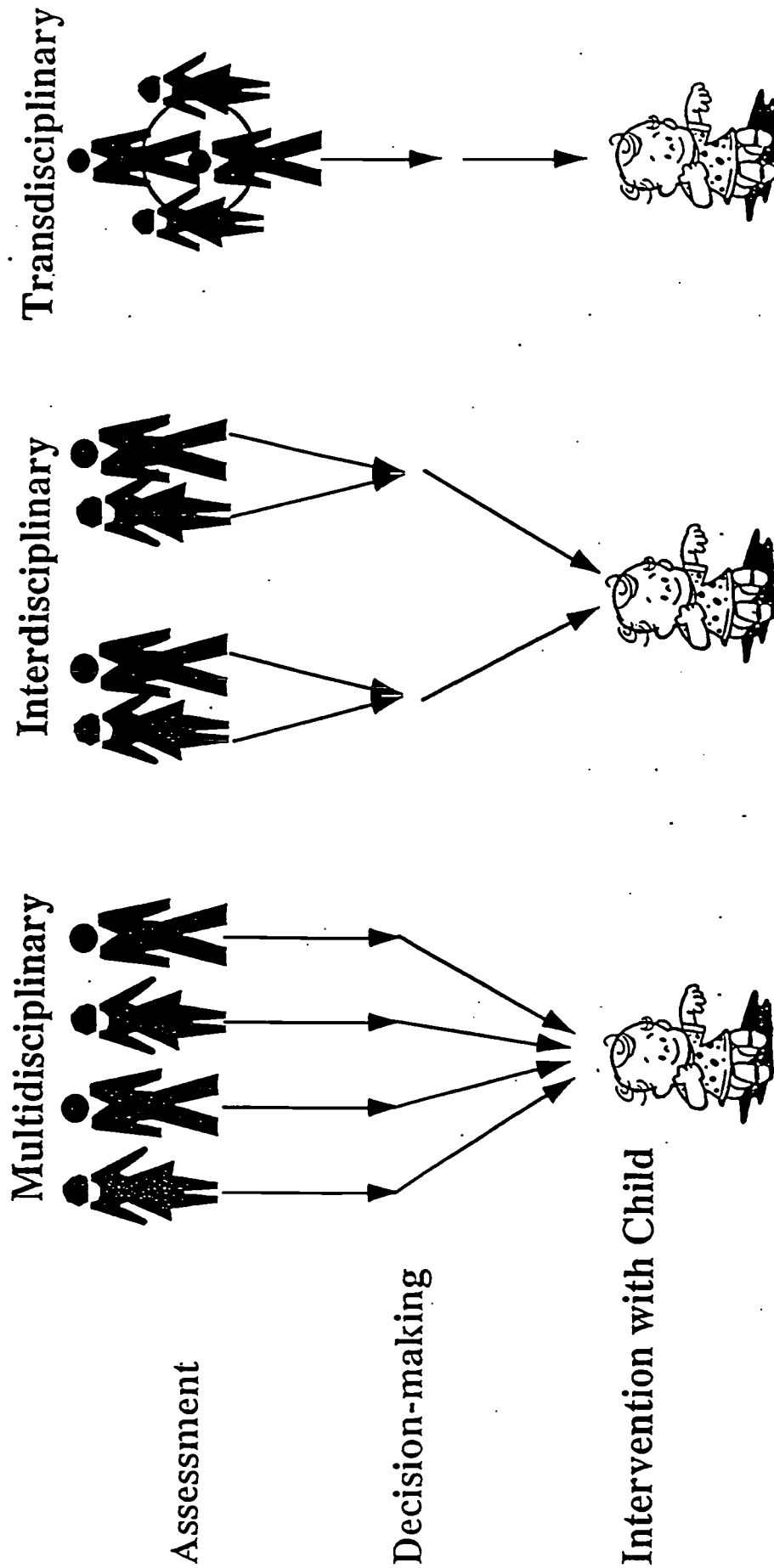
ARRANGEMENTS

- "Arena" Setting
  - conducted by two (or more)
    professionals and parent
  - time and effort efficient
    little duplication
  - nonindependent appraisals
    interobserver reliability?
  - prolonged session and multiple
    adults
    child endurance,
    overstimulation?

SELECTED DEC
RECOMMENDED PRACTICES
ON ASSESSMENT

Preassessment Activities

A1   Professionals contact families and share information about the assessment process.

A3   Professionals and families identify the questions and concerns that will drive the choice of assessment materials and procedures.

Procedures for Determining Eligibility, Program Placement, Program Planning, and Monitoring

A6   Professionals gather information from multiple sources (e.g., families, other professionals, paraprofessionals, and previous service providers) and use multiple measures (e.g., norm-referenced, interviews).

A10   Assessment approaches and instruments are culturally appropriate and nonbiased.

A12   Materials and procedures, or their adaptations, accommodate the child's sensory and response capacities.

Assessment Reports

A19   Professionals report assessment results in a manner that is immediately useful for planning program goals and objectives.

A21   Professionals report strengths as well as priorities for promoting optimal development.

A24   Professionals organize reports by developmental/functional domains or concerns rather than by assessment device.

DEC Recommended Practices
Assessment

Assessment in early intervention refers to the systematic collection of information about children, families, and environments to assist in making decisions regarding identification, screening, eligibility, program planning, monitoring, and evaluation.

Preassessment Activities

A1.   Professionals contact families and share information about the assessment process.

A2.   Professionals solicit and review existing information from families and agencies.

A3.   Professionals and families identify the questions and concerns that will drive the choice of assessment materials and procedures.

A4.   Professionals and families identify pertinent agencies, team members, and team approaches to be employed (e.g., inter-, multi-, transdisciplinary approach).

A5.   Professionals and families identify a mode of teaming that fits individual children's needs and families' desires to collaborate.

Procedures for Determining Eligibility, Program Placement, Program Planning and Monitoring

A6.   Professionals gather information from multiple sources (e.g., families, other professionals, paraprofessionals, and previous service providers) and use multiple measures (e.g., norm-referenced, interviews, etc).

A7.   Professionals gather information on multiple occasions.

A8.   Team members discuss qualitative and quantitative information and negotiate consensus in a collaborative decision-making process.

A9.   Team members select assessment instruments and procedures that have been field-tested with children similar to those assessed for the purposes intended.

A10.   Assessment approaches and instruments are culturally appropriate and nonbiased.

A11.   Professionals employ individualized, developmentally compatible assessment procedures and materials that capitalize on children's interests, interactions, and communication styles.

A12.   Materials and procedures, or their adaptations, accommodate the child's sensory and response capacities.

A13.   Professionals assess strengths as well as problems across developmental or functional areas.

A14.   Measures and procedures facilitate education and treatment (i.e., intervention or curriculum objectives) rather than only diagnosis and classification.

A15.   Measures are sensitive to child and family change.

A16.   Professionals assess not only skill acquisition, but also fluency, generalization, and quality of progress.

A17.   Professionals maintain confidentiality and discretion when sharing information.

A18.   Curriculum-based assessment procedures are the foundation or "mutual language" for team assessment.
Assessment Reports

A19.   Professionals report assessment results in a manner that is immediately useful for planning program goals and objectives.

A20.   Professionals report assessment results so that they are understandable to and useful for families.

A21.   Professionals report strengths as well as priorities for promoting optimal development.

A22.   Professionals report limitations of assessments (e.g., questions of rapport, cultural bias, and sensory/response requirements).

A23.   Reports contain findings and interpretations regarding the interrelatedness of developmental areas (e.g., how the child's limitations have affected development; how the child has learned to compensate).

A24   Professionals organize reports by developmental/functional domains or concerns rather than by assessment device.

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- Play-based Assessment

- uses natural play to detect skills
- promotes collaborative efforts
- can be done at home or clinic
- informal, low stress

#27

- Decisions must be made regarding who can receive professional services at taxpayer's expense.

- Public Law (PL 99-457, Part H) describes regulations for infants and toddlers with disabilities

  (1) Developmental delay in one or more developmental domain state discretion for criteria

    - number of months delay
    - percent delay
    - standard deviation
    - clinical judgment

#28

(2) Diagnosed condition with a
    high probability of resulting in
    developmental delay, for
    example:

    - Down syndrome

    - fetal alcohol syndrome

    - severe attachment disorders

    - inform errors of metabolism

    - microencephaly

    - and others

(3) Risk of having substantial delay
    if early intervention services are
    not available

    - state discretion

#29

- Experts suggest "Delayed Diagnosis"
    - problems in predicting early development
    - poor psychometric materials for infant assessment

Eligibility should be based on convergent evidence, not just test scores

Tests don't make decisions--people do!

#30

CLOSE-UP ON PROGRAM PLANNING AND MONITORING

Assessment should

- Identify teachable goals and objectives

- Identify child's emerging skills and entry points in program's curricular sequences

- Be sensitive to ongoing child progress within program curriculum

- Offer information on preferred teaching methods

- Document cumulative progress for program evaluation

#31

- ## WHAT ARE FOUR RECOMMENDED STANDARDS FOR ASSESSMENT?

1. Treatment Validity	Assessment must be useful for early intervention and education.
2. Social Validity	Assessment must be judged as valuable and acceptable, especially by families.
3. Convergent Assessment	Assessment must be based on an inclusive information base.
4. Consensual Validity	Assessment-based decisions must be reached through agreement of the participants.

#32

Treatment Validity

(Is assessment useful?)

Does assessment identify feasible goals and objectives for the child and family?

Does assessment information assist in the selection or use of instructional methods or approaches?

Does assessment contribute to evaluating intervention effects?

#33

Social Validity

(Is assessment acceptable?)

Does assessment identify goals and objectives that are judged as worthwhile and appropriate?

Are assessment methods and materials acceptable to participants?

Does the assessment detect social significance of change?

#34

Convergent Validity

(Is assessment inclusive?)

Are several types of assessment materials and approaches
used?

Is information collected from several settings and sources, especially from family members?

Are assessments done on more than one occasion?

#35

Consensual Validity

(Do parents and professionals agree?)

Is information pooled and perspectives shared?

Do team dynamics favor collaboration and negotiations?

Are decisions truly consensual?

#36

Convergent Assessment for Early Intervention
Multi-Dimentional Model

299

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DEC RECOMMENDED PRACTICES
ON ASSESSMENT

Preassessment Activities

A1 Professionals contact families and share information about the assessment process.

A3 Professionals and families identify the questions and concerns that will drive the choice of assessment materials and procedures.

Procedures for Determining Eligibility, Program Placement, Program Planning, and Monitoring

A6 Professionals gather information from multiple sources (e.g., families, other professionals, paraprofessionals, and previous service providers) and use multiple measures (e.g., norm-referenced, interviews).

A10 Assessment approaches and instruments are culturally appropriate and nonbiased.

A12 Materials and procedures, or their adaptations, accommodate the child's sensory and response capacities.

Assessment Reports

A19 Professionals report assessment results in a manner that is immediately useful for planning program goals and objectives.

A21 Professionals report strengths as well as priorities for promoting optimal development.

A24 Professionals organize reports by developmental/functional domains or concerns rather than by assessment device.

#38

CHECKLIST FOR ASSESSMENT STANDARDS

	No	Rarely	Yes
Treatment Validity			
1. Does assessment identify feasible goals and objectives for the child and family?			
2. Does assessment information assist in the selection or use of instructional methods or approaches?			
3. Does assessment contribute to evaluating intervention effects?			
Social Validity			
4. Does assessment identify goals and objectives that are judged as worthwhile and appropriate?			
5. Are assessment methods and materials acceptable to participants?			
6. Does the assessment detect social significance of change?			
Convergent Validity			
7. Are several types of assessment materials and approaches used?			
8. Is information collected from several settings and sources, especially from family members?			
9. Are assessments done on more than one occasion?			
Consensual Validity			
10. Is information pooled and perspectives shared?			
11. Do team dynamics favor collaboration and negotiations?			
12. Are decisions truly consensual?			

#39

Helping Infants, Toddlers, and
Young Children to Grow, Learn, and
Participate in Their
NATURAL ENVIRONMENTS

Contents

Prepared by
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Northeastern Early Intervention Faculty Training Institute
December 1993

OBJECTIVES

By the end of this module, the participant will be able to:

A.   Describe types of natural environments in which early intervention services could occur.

B.   Provide a rationale for the delivery of early intervention services in natural group environments.

C.   Describe service delivery parameters for providing early intervention in the home.

D.   List examples of interventions that could occur within a family's home and natural group environments.

E.   Describe naturalistic teaching strategies to use when embedding a child's developmental goals into activities and routines within natural group environments.

F.   Define the term natural environments as contained in Part H of the Individuals with Disabilities Education Act (IDEA).

OUTLINE

This module is organized as a one-hour session designed to provide participants with an overview of the importance of early intervention within natural environments. Professionals need to understand the impact that the learning environment has on both the child and the family. This module will define the term natural environment, describe the types of services that can be successfully delivered in natural environments, and describe the techniques for designing interventions in natural environments.

I.   Natural Environments

A.   Types of natural environments

B.   Individual determination of natural environments

---

        1.   Family priorities, resources, and concerns

    C.   History and rationale for inclusion in natural group environments

    D.   Requirements of P.L. 102-119

II.   Designing interventions

    A.   Interventions in the home

        1.   Family routines and activities
        2.   Scheduling visits
        3.   Use of visits

    B.   Interventions in natural group environments

        1.   Activities and routines in an environment
        2.   Collaborative consultation

    C.   Teaching strategies

        1.   Embedding goals into activities and routines
        2.   Adaptations and supports

EXPLANATORY MATERIALS AND INSTRUCTIONAL GUIDE

Natural Environments

A variety of factors influence the decision about the optimum service setting for an infant or toddler with disabilities. These include the location of the intervention program (i.e., urban vs. rural), the program's space allocation, the needs of the child, the transportation resources of the family and program, and the preference of the family. Early intervention can be provided in a hospital setting, a child care setting (a center, family day care home, or baby sitter's house), the home, and community. Clearly, there is no standard setting in which to provide early intervention to an infant or toddler.

P.L. 102-119 also uses the plural form of the term "natural environments," suggesting that not all services have to be provided at the same location; the settings may change over time as the needs of the family and child change. The most important aspect of the setting is that the family determines the environment in which the infant or toddler would be if he/she was not in need of early intervention. Additionally, it is extremely important that no matter where the intervention services occur, the intervention techniques are transferable within all of the environments in which the child and family participate.

Many times, families are restricted from participating in community activities and everyday routines if their child has a disability. Early interventionists should help the family identify the natural community environments in which the family would like to participate (shopping, church, library, etc.). Intervention routines should be used to empower the family to participate in as many of these natural environments as they wish.

Children with disabilities benefit from participating in group settings with children without disabilities; in fact, this practice, which has most recently been termed inclusion, has been cited as a quality indicator of early childhood and early intervention services. The data that support the practice of inclusive early intervention services within natural group environments were derived from a conceptual base that emphasizes the social/ethical, educational, and legal reasons for the integration of young children with disabilities with young children without disabilities. In particular, the legal rationale for this practice has recently been strengthened by the passage of both education legislation (IDEA, Part H) and civil legislation (Americans with Disabilities Act [ADA]). These laws support the right of young children with disabilities to participate in natural environments such as nursery schools and day care programs with children without disabilities. As a result, both families and professionals have articulated the importance of providing interventions to young children with disabilities within group settings that also serve young children without disabilities. In particular, four service delivery developments for the expansion of specialized services such as early intervention into natural group environments are summarized:

1. Data collected from both families and service providers have suggested the importance of integrating persons with disabilities into all aspects of society from the earliest point possible. This has created an impetus within public schools to expand special education instruction into the community, as well as into the mainstream of regular education. Recognizing this trend, early intervention special education programs, which serve infants and young children with disabilities, have begun to provide community-based service delivery models that facilitate inclusion in settings and activities in which same age peers fully participate.

2. Families have become increasingly vocal about their expectations for their children with disabilities. It has been well documented that parents of young children with disabilities want their children to have opportunities to receive intervention in the mainstream. These parents have also suggested that one of the most important outcomes of special education should be the development of friendships between their children and children without disabilities. Special educators, as well as other service providers for children with disabilities, are responding to expectations like these by revamping early intervention curricula to focus on the facilitation of social competence and friendships between children with and without disabilities. A collateral finding in these demonstration projects has been that parents of young children without disabilities who have participated in integrated preschool programs have reported positive attitudes toward this practice.

3. There is an increasing demand for child care services for young children. Over 5 million children are in the care of 1.5 million child care providers; it is projected that this number will continue to grow. There is no difference in the needs of families who have children with disabilities -- *everyone* needs child care. In order to meet this demand for quality child care for programs with disabilities, it has been suggested that early intervention programs change their service delivery strategy -- moving away from segregated early intervention programs and instead delivering their services within typical

child care settings. Model demonstration and pockets of best practice have provided evidence for its use by ensuring that appropriate supports are in place, although some child care programs have reported problems (e.g., high staff turnover, inaccessible buildings) that can be exacerbated by inclusive programs. In particular, it has been suggested that training resources are a necessity to increase the availability. This training must be available to families, child care providers, and resource and referral agencies.

4. The enactment of the landmark civil rights legislation on July 26, 1990, Americans with Disabilities Act, P.L. 101-336, prohibits discrimination against individuals with disabilities by state and local government-operated services for children. These services, such as child care centers, pre-schools, park and recreation services, library services, cannot exclude from participation in or deny the benefits of their services, programs, or activities, or otherwise discriminate against a child with disabilities (P.L. 101-336, Sec. 202). Moreover, the United States Department of Justice, in their highlights of Title II states, "Integration of individuals with disabilities into the mainstream of society is fundamental to the purposes of the Americans with Disabilities Act" (p. 5, Appendix N, ADA Handbook). Within the named entities defined as public accommodations under Title III, the following are included: "a nursery school a day care center. . .or other social service center establishment. . .a gymnasium, health spa, or other place of exercise or recreation" (sec. 301(7)).

The environment in which a child grows affects the development of the child's behavioral, social, and learning competence. When children with developmental disabilities remain in their natural environments, these norms are continually modeled and reinforced by the family and the community. When intervening in the natural environment, peers without disabilities become role models, stimulating the development of newly acquired skills and improving social competence.

Designing Interventions in Natural Environments

It is not surprising that most early intervention programs tend to be home based or set in the caregiving environment used by the family. When services are provided in the home, parents have the opportunity to become an integral part of the intervention process in their own natural environments. Furthermore, the child and family receive individualized attention because of the one-to-one nature of instruction within the home. When utilizing these natural environments, it is essential to provide a family-centered approach to early intervention. Routines and activities (eating, playing, bathing) should be identified and used as the primary mode of intervention. Bazyk (1986) suggests the following guidelines for home-based intervention:

a. The parent is the decision-maker.

b. The parent is first a parent, then the teacher or therapist.

c. Programs are developed by the provider and the parent and based upon the best principles of family-centered early intervention.

d. Each family is different in their willingness, desire, and motivation to participate in early intervention.

e. Parents have options about services they need and want.

f. The child's needs must be viewed in the context of the family.

It is important to ensure that families also have the opportunity to approve the schedule, format, and number of people who provide home-based services. The early intervention staff must be willing to accommodate the needs of individual families. This may mean scheduling visits during evenings, weekends, or at times when the family thinks it will be most beneficial. Likewise, each family may have certain routines they wish to continue, which means the home visitor(s) should allow the family to establish the format for the home visit. It is also important to remember that the family should approve all who visit, especially when more than one interventionist is going to the home.

If the child attends a group child care program, intervention should be provided within the natural routines and activities of this setting. For example, range of motion and balance exercises could be incorporated in the child's normal dressing, diapering, and playing routines. It is most important that the interventionist who provides services to the child also teach the caregivers within the child care setting how to carry out the child's intervention. This can be done through a process called collaborative consultation. This process shifts the emphasis away from the "specialist" as the only interventionist into a broader application of intervention throughout the daily schedule.

Section 677(d)(5) of P.L. 102-119 (the reauthorization of Part H of IDEA) states that "the Individualized Family Service Plan must contain a statement of the natural environments in which early intervention services shall appropriately be provided." This is further explained to mean that the most natural environment for an infant is the home; however, when group settings are utilized for intervention, the infant or toddler with a disability should be placed in groups, such as play groups, day care centers, or whatever typical group setting exists, with same age peers without disabilities (p. 12, House Report).

Naturalistic Teaching Strategies

Naturalistic teaching strategies are based on the normal interactions that occur between children and adults. Very little adaptation is needed to use these techniques with children with disabilities and their families. Incidental teaching, verbal prompting, and interrupted routines are some examples of natural interventions that can occur in the family's home and community. Intervening in a child's natural environment does not mean that the environment cannot be altered; however, the environment should approximate as closely as possible the environment in which the child would normally be if she/he had no disabilities.

A variety of services could easily be provided for a child with a disability in natural environments. For example, during a child's normal dressing routine, activities could be performed to increase the child's physical strengths and communication skills. Specifically, range of motion, balancing, reaching, grasping, supporting weight, rolling, and game playing activities would increase physical strength, while naming and finding items of clothes could increase communication skills. The task of the interventionist is to identify the child's daily activities and routines in

natural environments (home or group) and embed the child's developmental goals and objectives within the activities.

A second task is to incorporate specific intervention strategies within the activities utilizing adaptation as necessary. These adaptations should be focused on empowering the child to participate in all of the activities and routines in the environment. Adaptations are also called supports and these may encompass a number of strategies, such as using different materials for the child during an activity, providing physical assistance to the child during the activity, or changing the goal of the activity for the child. For example, a child who does not have speech could be taught to use a gesture or a sign to indicate his/her wants and needs. Likewise, a child could use puzzles that have been adapted with dowels to accommodate for his/her lack of finger dexterity. The concept of natural teaching strategies means that the child's development goals will be addressed throughout natural activities and routines using strategies to maximize the child's independent participation within the activity.

Instructional Guide

Introduction to Session: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 1 - Objectives Handout 1 - Class notes	**Overview of the Module:** Professionals need to understand the impact that the learning environment has on both the family and the child. Traditionally, the family and child have received most services outside of their natural environments, that is, in a place different then children without disabilities. The purpose of this module is to define natural environments and supply the learner with the rationale and methods for delivering services within natural environments. **List and briefly review the objectives for the session.**
Natural Environments: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 2 - Natural Environments	Define the term natural environments, specifically to Part H of IDEA. Have the class come up with a list of factors that would influence the optimum setting for service (e.g., location of the intervention program, program's space allocation, needs of the infant, transportation resources, preference of the family).
Transparency 3 - Types of Natural Environments	Discuss the different types of natural environments (e.g., family home, child care center [center or family day care], hospital or clinic setting, the community).
Interventions in Natural Group Environments: 10 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 4 - Rationale	Discuss the data supporting natural group environments. The natural environment rationale is legally supported by Part H of the IDEA and by the ADA.

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Designing Interventions in the Natural Environment: 15 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 5 - Early Intervention in Natural Environments	List the concerns that must be taken into account when early intervention takes place in natural environments: (e.g., What are the child's needs?, What are the family's needs?, What does the family identify as the natural environment(s)?, What are the identified activities or outcomes?, What are the supports/services needed to conduct activities or attain outcomes?, Can these activities/supports/services be provided in the identified natural environments?, If not, what are the barriers, and what are the strategies to overcome the barriers?)
Transparency 6 - Collaborative Consultation	Describe the use of collaborative consultation.
Transparency 7 - Natural Teaching Techniques	Describe how natural teaching techniques can be used in early intervention (e.g., incidental teaching, verbal prompts, time-delay prompts, interrupted routines, interesting materials, behavior trapping).

Examples of Interventions that Could Occur in Natural Environments: 10 minutes	
Media/Materials	**Content and Learning Activities**
Transparencies 8, 9, 10, 11 - Embedding a Child's Goals into Natural Environments	Describe why and how the learning activity sheet is used (e.g., to describe the child's routines and activities, list the child's developmental goals, assign the goals to particular activities).
Transparency 12 - Supports and Adaptations	Describe how activities and routines can be adapted to accommodate a child's needs.

Conclusion: 5 minutes	
Media/Materials	**Content and Learning Activities**
	Restate how important natural environments are to the family and child.
	Administer the evaluation.

PARTICIPANT EVALUATION

1.   You are talking to a family who has a child with special needs. The parents do not understand the term natural environments; it is your job to explain it to them. Make sure that your response contains the specifications stated in P.L. 102-119.

_____

_____

_____

_____

_____

2.   You are the service coordinator for David and his family. David is a 2-year-old boy with hearing impairments. Starting next month, he will be attending a family day care center. The family wants David to learn to interact with other children his age. Who would help David learn these skills?

_____

_____

_____

_____

_____

3. Using the scenario in question #2, state the rationale for the delivery of early intervention services in the child care center.

_____

_____

_____

_____

_____

4. Sue and Bob just brought their baby girl, Reida, home from the hospital. Reida was born prematurely at 24 weeks. Describe the service delivery parameters for designing early intervention in the home.

_____

_____

_____

_____

_____

5. Using the scenario in question #2, list examples of interventions that could occur within the family home.

_____

_____

_____

_____

RESOURCE LIST

Videotapes

The Northcentral Ohio Special Educational Regional Resource Center. (1992). *Early childhood education AT ITS BEST*. [For more information, call 419-747-4808 or 800-424-7372.]

Ohio Department of Education, Division of Early Childhood Education. (1992). *Early childhood education at its best*. [Available from Northcentral Ohio Special Education Resource Center, 2200 Bedford Road, Mansfield, Ohio 44906, 419-747-4808, 800-424-7372.

Print Materials and Curricula

Noonan, M., & McCormick, L. (1993). *Early intervention in natural environments: Methods and procedures*. Belmont, CA: Wadsworth.

Peck, C., Odom, S., & Bricker, D. (1992). *Integrating young children with disabilities into community programs: Ecological Perspectives on research and implementation*. Baltimore: Brookes.

Readings

AGH Associates, Inc. (1993). *Inclusion: A teacher's guide*. Hampton, NH: Author.

Bricker, D., & Cripe, J. (1992). *An activity-based approach to early intervention*. Baltimore: Brookes.

Bruder, M. (1993). The provision of early intervention and early childhood special education within community early childhood programs: Characteristics of effective service delivery. *Topics in Early Childhood Special Education, 13*(1), 19-87.

Mahoney, G., O'Sullivan, P., & Dennenbaum, J. (1990). A national study of mothers' perceptions of family-focused early intervention. *Journal of Early Intervention, 14*(2), 133-146.

Noonan, M. J., & McCormick, L. (1992). A naturalistic curriculum model for early intervention. *The Transdisciplinary Journal, 2*(3), 147-159.

Noonan, M. J., & McCormick, L. (1993). *Early intervention in natural environments: Methods and procedures.* Belmont, CA: Brooks/Cole Publishing.

Odom, S., & Karnes, M. (1988). *Early intervention for infants and children with handicaps: An empirical base.* Baltimore: Brookes.

Odom, S. L., McConnell, S. R., & McEvoy, M. A. (1992). *Social competence of young children with disabilities: Issues and strategies for intervention.* Baltimore: Brookes.

Peck, C. A., Odom, S. L., & Bricker, D. D. (1993). *Integrating young children with disabilities into community programs: Ecological perspectives on research and implementation.* Baltimore: Brookes.

SUGGESTED ACTIVITIES FOR EXPANSION OF MODULE CONTENTS

This section includes two activities that can be used to expand the contents of this module. The time required for each activity, the materials required, and other information is provided with the description of each activity. Activities may be carried out in separate sessions, used to expand this module into a longer than one-hour session, or embedded within the module to illustrate practices of delivering services in natural environments.

Activity 1: Designing Intervention in Natural Environments	
Purpose	To give the learner an opportunity to see how a special service can be delivered in natural environments.
Activity Sequence	Each group will be provided with a description of a child, a service, an environment, and a "teacher" (see following page). The group will take this information and design a method for delivering this service to the child in the natural environment without disrupting other events going on in the environment.
Length	20 minutes of group discussion; 10 minutes of group presentation
Materials	None
Source	Northeastern Early Intervention Faculty Training Institute

Situation 1

A 3-month-old child who has to perform a range of motion exercises. The provider will be the parents and the environment is the family home. How will these activities be incorporated into the family's normal routines?

Situation 2

A 2-year-old child who needs to work on his/her non-verbal communication skills. The environment is a day care center with 16 other children (5 months to 3 years old). The staff at the center will be responsible for most of the intervention. How can these activities be incorporated into the center's normal routines?

Situation 3

A 1-year-old child who needs to develop fine motor skills. The environment is the family home and all family members (father, mother, sister, 8, and brother, 6) will assist with the intervention. How can each member of the family help develop the child's motor skills?

Situation 4

A 3-year-old child who needs to develop verbal communication skills. The environments are the preschool classroom, where the teacher is the service provider, and the family home, where the family members are the providers. How can the family and teacher work together to develop the child's communication skills?

Situation 5

A 2-year-old child who needs to develop social communication skills. The environment is a family day care center with four other children and the provider is a day care mother.

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Activity 2	
Activity Sequence	Interview any family with children. Determine the family's normal routines, values, and culture. Find out how the family cares for their child during working hours (i.e., Do both parents work? Where do the children go for care?). Using this information, design an intervention plan for developing non-verbal communication skills for a 2-year-old child with hearing impairments.
Materials	None
Source	Northeastern Early Intervention Faculty Training Institute

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PARTICIPANT HANDOUTS

Handout 1

The Participant Lecture Notes are notes pages that correspond to the transparencies.

1

Helping Infants, Toddlers, and Young Children to Grow, Learn, and Participate in Their NATURAL ENVIRONMENTS

By the end of this module, the participant will be able to:

- Describe types of natural environments in which early intervention services could occur.

- Provide a rationale for the delivery of early intervention services in natural group environments.

- Describe service delivery parameters for providing early intervention in the home.

- List examples of interventions that could occur within a family's home and natural group environments.

- Describe naturalistic teaching strategies to use when embedding a child's developmental goals into activities and routines within natural group environments.

- Define the term natural environments as contained in Part H of the Individuals with Disabilities Education Act (IDEA).

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Natural Environments: The Law

"To the maximum extent appropriate, infants and
   toddlers must be provided early intervention
   services in natural environments, including the
   home, and community settings such as day care
   centers, in which children without disabilities
   participate."

"A statement of the natural environment in which
   the early intervention services shall
   appropriately be provided" in the IFSP.

P.L. 102-119

"The term 'natural environments' refers to settings
   that are natural or normal for age peers who have
   no apparent disability."

H.R. 3050

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Types of Natural Environments

- Family home

- Child care center (center or family day care)

- Hospital or clinic setting

- Community settings

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Rationale

- Trends in Special Education for Inclusion

- Families' Request for Friendships

- Increasing Need for Child Care

- Law

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Early Intervention in a Natural Environment

- Identify the child's needs

- Identify the family's needs

- Identify the natural environment

- Identify the activities and outcomes

- Identify the services/supports needed to conduct the activities or attain the outcomes

- Identify any barriers to providing services in the natural environment

- Develop strategies to overcome the barriers

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Collaborative Consultation

An interactive process that [empowers] people with diverse expertise to generate creative solutions to mutually defined problems.

The major outcome is to provide comprehensive and effective programs for students with special needs within the most appropriate context, thereby [empowering] them to achieve maximum constructive interaction with [peers without disabilities.

Idol, Paolucci-Whitcomb, & Nevin, 1986

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Natural Teaching Techniques

- Incidental Teaching

- Verbal Prompts

- Time-delay Prompts

- Interrupted Routine

- Interesting Materials

- Behavior Trapping

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Input Home Routines

Wake-up	Dressing	Feeding	Playtime	Riding in Car	Bathtime

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Natural Environments Transparency #9

Input Learning Objectives

Learning Objective	Wake-up	Dressing	Feeding	Play-time	Riding in Car	Bath-time
Lifts head when prone to view visual displays or be responded to socially						
Uses "social bids" (e.g., smiling & vocalization) to initiate adult-child interactions						
Uses kicking movements to produce movement of a mobile						
Using cooing sounds to evoke adult responsiveness						
Activates a music box using voice activated microphone						

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Natural Environments Transparency #10

Input Group Routines

Learning Objectives	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Input Learning Objectives
for Group Activities

Learning Objective	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions
Will use non-verbal gestures to request objects or actions					
Will follow simple directions within the context of play					
Will use a spoon and cup independently to feed self					
Will engage in independent, socially appropriate play with toys					
Will communicate yes and no using head movements					

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Activities

Activity	Person Res- ponsible	Loca- tion	As is	With Adapted Materials	With Personal Assis- tance	With Adapted curr./ goals	Specific Adap- tations

Northeastern Early Intervention Faculty Training Institute, 1993

Lecture Notes

Helping Infants, Toddlers, and Young
Children to Grow, Learn, and Participate in
Their NATURAL ENVIRONMENTS

By the end of this module, the participant will be able to:

- Describe types of natural environments in which early intervention services could occur.

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- Describe service delivery parameters for providing early intervention in the home.

- List examples of interventions that could occur within a family's home and natural group environments.

- Describe naturalistic teaching strategies to use when embedding a child's developmental goals into activities and routines within natural group environments.

- Define the term natural environments as contained in Part H of the Individuals with Disabilities Education Act (IDEA).

Natural Environments: The Law

"To the maximum extent appropriate, infants and toddlers must be provided early intervention services in natural environments, including the home, and community settings such as day care centers, in which children without disabilities participate."

"A statement of the natural environment in which the early intervention services shall appropriately be provided" in the IFSP.

P.L. 102-119

"The term 'natural environments' refers to settings that are natural or normal for age peers who have no apparent disability."

H.R. 3050

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Types of Natural Environments

- Family home

- Child care center (center or family day care)

- Hospital or clinic setting

- Community settings

Rationale

- **Trends in Special Education for Inclusion**

- **Families' Request for Friendships**

- **Increasing Need for Child Care**

- **Law**

Early Intervention in a Natural Environment

- Identify the child's needs

- Identify the family's needs

- Identify the natural environment

- Identify the activities and outcomes

- Identify the services/supports needed to conduct the activities or attain the outcomes

- Identify any barriers to providing services in the natural environment

- Develop strategies to overcome the barriers

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Collaborative Consultation

An interactive process that [empowers] people with diverse expertise to generate creative solutions to mutually defined problems.

The major outcome is to provide comprehensive and effective programs for students with special needs within the most appropriate context, thereby [empowering] them to achieve maximum constructive interaction with [peers without disabilities.

Idol, Paolucci-Whitcomb, & Nevin, 1986

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Natural Teaching Techniques

- **Incidental Teaching**

- **Verbal Prompts**

- **Time-delay Prompts**

- **Interrupted Routine**

- **Interesting Materials**

- **Behavior Trapping**

Input Home Routines

Wake-up	Dressing	Feeding	Playtime	Riding in Car	Bathtime

Input Learning Objectives

Learning Objective	Wake-up	Dressing	Feeding	Play-time	Riding in Car	Bath-time
Lifts head when prone to view visual displays or be responded to socially						
Uses "social bids" (e.g., smiling & vocalization) to initiate adult-child interactions						
Uses kicking movements to produce movement of a mobile						
Using cooing sounds to evoke adult responsiveness						
Activates a music box using voice activated microphone						

Input Group Routines

Learning Objectives	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions
		343			

Input Learning Objectives for Group Activities

Learning Objective	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions
Will use non-verbal gestures to request objects or actions					
Will follow simple directions within the context of play					
Will use a spoon and cup independently to feed self					
Will engage in independent, socially appropriate play with toys					
Will communicate yes and no using head movements			344		

ERIC
Full Text Provided by ERIC

Activities

Activity	Person Res-ponsible	Loca-tion	As is	With Adapted Materials	With Personal Assis-tance	With Adapted curr./ goals	Specific Adap-tations
				345			

Northeastern Early Intervention Faculty Training Institute, 1993

Increasing the Number of Learning
Opportunities for a Child by Using
ACTIVITY BASED APPROACHES TO
INTERVENTION

By the end of this module, the participant will be able to:

- Describe activity based approaches to intervention

- Define the role of the interventionist

- Describe the techniques used to implement activity based intervention

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Principles of Activity Based Intervention

- Learning events are child directed

- Learning events occur during normal activities

- Routines and activities contain naturally occurring reinforcements

- Learning events develop real world skills

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Positive Aspects of Activity Based Instruction

- **Targets many objectives within the context of one activity**

- **Uses naturally occurring reinforcements**

- **Gives the child a variety of opportunities to practice skills during their daily activities**

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The Interventionist's Role

- **Identify the child's daily activities and embed the child's developmental goals and objectives within the activities**

- **Incorporate specific intervention strategies within the activities**

- **Train other providers in using activity based approaches to intervention**

Intervention Strategies

Forgetfulness	⇨	Forgetting an important component of a routine or activity
Novelty	⇨	Introducing something new into a familiar activity
Visible but Unreachable	⇨	Placing objects within the child's view, but out of reach
Violation of Expectations	⇨	Omitting a familiar step of an activity
Piece by Piece	⇨	Continuing with each step of an activity at the child's request
Assistance	⇨	Setting-up the materials for an activity such that the child needs adult assistance
Sabotage	⇨	Interfering with an activity that the child is conducting or participating in
Interruption or Delay	⇨	Stopping an activity verbally or with silence, awaiting the child's response

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Input Home Routines

Wake-up	Dressing	Feeding	Playtime	Riding in Car	Bathtime

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ERIC

Input Learning Objectives

Learning Objective	Wake-up	Dressing	Feeding	Play-time	Riding in Car	Bath-time
Lifts head when prone to view visual displays or be responded to socially	X			X		X
Uses "social bids" (e.g., smiling & vocalization) to initiate adult-child interactions	X	X		X	X	
Uses kicking movements to produce movement of a mobile		X		X		
Using cooing sounds to evoke adult responsiveness	X	X	X	X	X	X
Activates a music box using voice activated microphone			352	X	X	

Northeastern Early Intervention Faculty Training Institute, 1994

Input Group Routines

Learning Objectives	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions
		353			

Input Learning Objectives for Group Activities

Learning Objective	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions
Will use non-verbal gestures to request objects or actions	X	X	X	X	
Will follow simple directions within the context of play	X	X		X	
Will use a spoon and cup independently to feed self			X		
Will engage in independent, socially appropriate play with toys	X	X		X	
Will communicate yes and no using head movements	X	X	354 X	X	

Activities

Activity	Person Responsible	Location	As is Y/N	With Adapted Materials	With Personal Assistance	With Adapted curr./ goals	Specific Adaptations
Snack	Teacher	Table	N	N	N	Y	Child will sign for cookies and juice
Puzzle	Teacher	Puzzle Corner	N	Y			Dowels on puzzle pieces
					355		

Infusion Modules

Infants and Toddlers with Special Needs and Their Families

- Activity Based Approaches

OBJECTIVES

By the end of this module, the participant will be able to:

A.   Describe activity based approaches to intervention.

B.   Define the role of the interventionist.

C.   Describe the techniques used to implement activity based intervention.

OUTLINE

This module is organized as an hour-long session designed to provide the participants with an overview of the application of the activity based approach to early intervention. Professionals need to take advantage of the hundreds of learning opportunities present within a child's daily routines and activities. This module describes the activity based approaches to intervention, defines the role of the interventionist, and describes the techniques used to implement activity based interventions.

I.   Activity Based Approaches to Intervention

    A.   Four Basic Principles

        1.   Child initiates and/or directs the learning events.
        2.   Interventions occur within normal activities.
            a)   Routines
            b)   Planned activities
            c)   Child-initiated activities
        3.   The activity contains necessary precursors and responses.
        4.   The intervention develops functional skills.

II.   Implementing Activity Based Approaches

    A.   The Interventionist's Role
    B.   Intervention Strategies
    C.   Involvement of Other Professionals

EXPLANATORY MATERIAL AND INSTRUCTIONAL GUIDE

Activity Based Approaches to Intervention

The development of activity based approaches to intervention is the culmination of years of educational theory, research, and practice. Activity based approaches to intervention focus on the integration of learning events within the activities in which the child normally participates. These approaches allow the child's needs and interests to dictate where and when the interventions will take place, while the interventionist targets the specific learning objectives and goals. The four basic principles of activity based interventions are:

- the child directs the learning event,

- the learning event occurs during normal activities,

- the activities contain naturally occurring precursors and responses, and

- the learning events develop functional skills.

If the activity interests the child, the child's attention toward the activity will be enhanced. Activities that most interest children are ones they can select or direct. Once the activity has gained the child's attention, the interventionist, following the child's lead, embeds learning events within the given activity. When embedding these learning events, it is important that the interventionist does not lead the events. By letting the child lead, the activity motivates the child and maintains the child's attention. Using this approach, the child encounters the natural responses to their actions and develops proper social and environmental interactions.

Using this approach, opportunities for intervention become frequent and practical because the intervention takes place during all activities. Learning events can be embedded within three types of activities: routine, planned, and child-initiated. Routine activities occur at specific times or on a regular basis (e.g., waking up, getting dressed, eating a snack). Planned activities require adult supervision or participation (e.g., nature walk, water play, painting). Child-initiated activities require the child to initiate or pursue the activity (e.g., selecting a toy and playing

with it). An activity based intervention is successful when the activity possesses four distinct features. First, the child must understand the activity. The context of the activity must be familiar to the child to avoid confusion. Second, the activity must interest the child. When the activity interests the child, it motivates the child, therefore eliminating the need for extrinsic reinforcements. Third, the activity must be developmentally appropriate. The interventionist should tach new skills within the context of existing skills. Finally, activities should occur within the social and physical environments in which the child normally participates. By working in a familiar environment, the child views the activity as practical, thus making the new information or skill easier to generalize.

In order for a learning event to be successful, the activity chosen must lend itself to the targeted objective. The activity must contain the components or precursors necessary for learning the given skill. For example, when the objective is to build the child's motor skills and the activity is story time, the child will not learn or practice the targeted objective because the activity does not contain the necessary opportunities (the children are sitting in a circle, listening to a story). In addition to containing the necessary precursors, the activity should contain the necessary outcomes or responses. For example, when the objective is to teach the child to share and the activity is playing a game (containing the necessary precursors), the logical outcome is the child gets to take his/her turn. When the activity contains intrinsic reinforcements, there is less need for extrinsic reinforcements.

Finally, activity based interventions should teach functional skills. These skills must help the child become more independent. For example, to help a child function in their world, skills like washing hands, combing hair, and brushing teeth are more functional than teaching a child to stack blocks and hop like a frog. In addition to the skills being functional, the child must be able to generalize the new skills and information. For example, when teaching a child to identify a shoe, the teacher should show a variety of examples (e.g., sneakers, loafers, slippers, sandals) to the child.

By using the activity based approaches to intervention, the interventionist can target many learning objectives during one activity. For example, an interventionist can teach and measure many skills when children are sharing crayons. The coloring activity lends itself to producing communication skills (e.g., "I want [the] blue crayon"), social

skills (e.g., taking turns and using words like "please" and "thank you"), motor skills (e.g., reaching and grasping crayons), and cognitive skills (e.g., problem solving – finding and locating the blue crayon). Another positive aspect of using this approach is the occurrences of natural reinforcements. The enjoyment the child associates with an activity motivates the child to participate in the activity, therefore participating in the learning events.

Implementing Activity Based Interventions

Implementing activity based instruction relies heavily on the child's daily activities. However, this does not mean learning events are unplanned. The first task of the interventionist is to identify the child's daily activities in his/her natural environment (home or group) and embed the child's developmental goals and objectives within the activities. The interventionist will learn to capitalize on child-initiated activities, viewing all activities (routine, planned, and child-initiated) as opportunities to practice the objectives. By using this variety of circumstances, the child learns to generalize the new skills and information.

The second task of the interventionist is to incorporate specific intervention strategies within activities, utilizing adaptations as necessary. The interventionist should use adaptations only to enable the child to participate in the activities occurring within their environment. Several intervention strategies that the interventionist can naturally integrate into daily activities are:

- **Forgetfulness** - Forgetting an important component of a routine or activity.

- **Novelty** - Introducing something new into a familiar activity.

- **Visible but Unreachable** - Placing objects within the child's view, but out of reach.

- **Violation of Expectations** - Omitting a familiar step of an activity.

- **Piece by Piece** - Continuing with each step of an activity at the child's request.

- **Assistance** - Setting up the materials for an activity such that the child needs adult assistance.

- **Sabotage** - Interfering with an activity that the child is conducting or participating in.

- **Interruption or Delay** - Stopping an activity verbally or with silence, awaiting the child's response.

The interventionist should only use these strategies to assist in the child's development. Overuse of these strategies can be confusing and frustrating to the child and produce unwanted responses.

The final task of the interventionist is to train other providers (i.e., therapists, caregivers, parent, etc.) in the skills of activity based intervention. This technique can be used across all disciplines to address a variety of goals and objectives. Activity based interventions provide professionals with hundreds of opportunities to integrate specific therapies into the child's daily activities.

Instructional Guide

Introduction to Session: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 1 - Objectives Handout 1 - Class notes	**Overview of the Module:** Professionals need to take advantage of the hundreds of learning opportunities presented them within a child's daily activities. The purpose of this module is to describe the activity based approaches to intervention, define the role of the interventionist, and describe the techniques used to implement activity based interventions. **List and briefly review the objectives for the session.**

Activity Based Approaches to Intervention: 15 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 2 - Components of Activity Based Approaches	Define the four basic principles of activity based interventions: • learning events are child directed; • learning events occur during normal activities; • routines and activities contain naturally occurring precursors and responses; and • learning events develop functional skills.
Transparency 3 - Positive Aspects to Using the Activity Based Approaches to Intervention	Describe the positive aspects to using the activity based approaches to intervention: • targets many objectives within the context of one activity; • uses naturally occurring reinforcements; and • provides a variety of opportunities for practice during the child's daily activities.

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Implementing Activity Based Interventions: 15 minutes	
Media/Materials	**Content and Learning Activities**
Transparency 4 - The Interventionist's Role	Describe the role of the interventionist: • to identify the child's daily activities and embed the child's developmental goals and objective within the activities; • to incorporate specific intervention strategies within the activities; and • to train other providers in use of this approach to intervention.
Transparency 7 - Intervention Strategies	Describe the intervention strategies and how they should be integrated into daily activities: • Forgetfulness • Novelty • Visible but Unreachable • Violation of Expectations • Piece by Piece • Assistance • Sabotage • Interruption or Delay

Examples of Interventions That Could Occur in the Natural Environment: 5 minutes	
Media/Materials	**Content and Learning Activities**
Transparencies 6, 7, 8, and 9 - Embedding a Child's Goals into the Natural Environment	Describe why and how the learning activity sheet is used: • describes the child's daily activities; • lists the child's developmental goals; • assigns the goals to particular activities.
Transparency 10 - Supports and Adaptations	Describe how activities can be adapted to accommodate a child's needs.

Conclusion: 5 minutes	
Media/Materials	**Content and Learning Activities**
	Restate how useful the activity based approaches to intervention are to all professionals and children. **Administer the evaluation.**

PARTICIPANT EVALUATION

Ask the participants to respond to the following statements:

1. A nursery school teacher has a three-year-old child with poor fine motor skills in his/her classroom. The parents and teacher want to help the child develop the child's fine motor skills. Describe how activity based approaches to intervention could be used to help this child.

    _____

    _____

    _____

    _____

2. Susie, a two-year-child with a hearing impairment is entering a home daycare center. Susie's parents and communication specialist want to make sure that Susie continues to develop her communication skills through activity based intervention. Describe how the communication specialist, acting as the interventionist, would work with the daycare provider to implement these interventions.

    _____

    _____

    _____

    _____

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3. A daycare provider wants to improve the social communication skills of a group of children. What instructional strategies could the daycare provider embed into the children's snack time to develop these communication skills?

_____

_____

_____

_____

4. Describe a scenario of how one of the strategies identified in question three, could be used to intervene.

_____

_____

_____

_____

RESOURCE LIST

Bailey, D. B., & Wolery, M. (1992). Strategies for intervention: Teaching and the teaching process. In D. Bailey & M. Wolery (Eds.), *Teaching infants and preschoolers with disabilities* (pp. 127-160). New York: Merrill.

Bricker, D., & Cripe, J. (1992). *An activity based approach to early intervention.* Baltimore: Brookes.

Linder, T. W. (1993). *Transdisciplinary play-based intervention: Guidelines for developing a meaningful curriculum for young children.* Baltimore: Brookes.

McWilliam, R. A. (1992). *Family-centered intervention planning: A routines-based approach.* Tucson, AZ: Communication Skill Builders.

Morris, L. R., & Schulz, L. (1989). *Creative play activities for children with disabilities: A resource book for teachers and parents* (2nd ed.). Champaign, IL: Human Kinetics Books.

Musselwhite, C. (1986). *Adaptive play for special needs children.* San Diego: College Hill Press.

Noonan, M., & McCormick, L. (1993). *Early intervention in natural environments: Methods and procedures.* Belmont, CA: Wadsworth, Inc.

Wolery, M., & Fleming, L. A. (1993). Implementing individualized curricula in integrated settings. In C. Peck, S. Odom, & D. Bricker (Eds.), *Integrating young children with disabilities into community programs* (pp. 109-132). Baltimore: Brookes.

SUGGESTED ACTIVITIES FOR EXPANSION OF MODULE CONTENTS

This section includes two activities that can be used to expand the contents of this module. The time requirements for each activity, the materials required, and other information is provided with the description of each activity. Activities may be carried out in separate sessions, used to expand the module to a longer than one-hour session, or embedded within the module to illustrate practices of delivering services in a natural environment.

Activity 1	
Purpose	To give the learner an opportunity to see how an interventionist would plan learning events using activity based instruction.
Activity Sequence	Each student, acting as an interventionist, will observe a child at play to determine the types of activities the child likes. As the interventionist, you will then make a grid chart with activities across the top and developmentally appropriate objectives on the left side. Then the interventionist will assign the learning objectives to the child's daily activities.
Materials	Flipchart; Markers
Length	60 minutes of observation; 20 minutes of interviewing time
Source	Northeastern Early Intervention Faculty Training Institute

Activity 2	
Purpose	To give the learner an opportunity to see how an interventionist integrates learning events into a child's daily schedule using activity based instruction.
Activity Sequence	Each student, acting as an interventionist, will observe a child for one hour. As the interventionist, you identify strategies that the care provider (parent, daycare provider) could have used or did use to intervene to teach the child a developmentally appropriate skill.
Materials	none
Length	60 minutes of observation
Source	Northeastern Early Intervention Faculty Training Institute

PARTICIPANT HANDOUTS

Handout 1

The Participant Lecture Notes are notes pages that correspond to the transparencies.

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Increasing the Number of Learning
Opportunities for a Child by Using
ACTIVITY BASED APPROACHES TO
INTERVENTION

By the end of this module,
  the participant will be able
  to:

- Describe activity based
  approaches to intervention

- Define the role of the
  interventionist

- Describe the techniques
  used to implement activity
  based intervention

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Principles of Activity Based Intervention

- Learning events are child directed

- Learning events occur during normal activities

- Routines and activities contain naturally occurring reinforcements

- Learning events develop real world skills

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Positive Aspects of Activity Based Instruction

- Targets many objectives within the context of one activity

- Uses naturally occurring reinforcements

- Gives the child a variety of opportunities to practice skills during their daily activities

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

The Interventionist's Role

- Identify the child's daily activities and embed the child's developmental goals and objectives within the activities

- Incorporate specific intervention strategies within the activities

- Train other providers in using activity based approaches to intervention

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Intervention Strategies

Forgetfulness ⇨ Forgetting an important component of a routine or activity

Novelty ⇨ Introducing something new into a familiar activity

Visible but Unreachable ⇨ Placing objects within the child's view, but out of reach

Violation of Expectations ⇨ Omitting a familiar step of an activity

Piece by Piece ⇨ Continuing with each step of an activity at the child's request

Assistance ⇨ Setting-up the materials for an activity such that the child needs adult assistance

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Interruption or Delay ⇨ Stopping an activity verbally or with silence, awaiting the child's response

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Input Home Routines

Wake-up	Dressing	Feeding	Playtime	Riding in Car	Bathtime

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Input Learning Objectives

Learning Objective	Wake-up	Dressing	Feeding	Play-time	Riding in Car	Bath-time
Lifts head when prone to view visual displays or be responded to socially	X			X		X
Uses "social bids" (e.g., smiling & vocalization) to initiate adult-child interactions	X	X		X	X	
Uses kicking movements to produce movement of a mobile		X		X		
Using cooing sounds to evoke adult responsiveness	X	X	X	X	X	X
Activates a music box using voice activated microphone				X	X	

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Input Group Routines

Learning Objectives	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Input Learning Objectives
for Group Activities

Learning Objective	Arrival/ Departure	Circle Group Time	Snack/ Lunch	Free Play	Transitions
Will use non-verbal gestures to request objects or actions	X	X	X	X	
Will follow simple directions within the context of play	X	X		X	
Will use a spoon and cup independently to feed self			X		
Will engage in independent, socially appropriate play with toys	X	X		X	
Will communicate yes and no using head movements	X	X	X	X	

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

Activities

Activity	Person Responsible	Location	As is Y/N	With Adapted Materials	With Personal Assistance	With Adapted curr./ goals	Specific Adaptations
Snack	Teacher	Table	N	N	N	Y	Child will sign for cookies and juice
Puzzle	Teacher	Puzzle Corner	N	Y			Dowels on puzzle pieces

Northeastern Early Intervention Faculty Training Institute, 1994

Lecture Notes

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3. Explanatory Materials
4. Evaluation
5. Resource Material

Part Two *Supporting Materials*
1. Lecture Notes
2. Student Handout for Note-Taking
3. Additional Student Handouts
4. Transparency Samples

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3. Additional Student Handouts
4. Transparency Sample

Infants & Toddlers with Special Needs and Their Families

Teams & Teaming

INSTRUCTIONAL MODULE III

Infants and Toddlers With Disabilities and Their Families:

Teams and Teaming

PART ONE

I.   Objectives
II. Outline
III. Explanatory Materials
IV. Evaluation
V.   Resource Material

Instructional Module III

Infants and Toddlers with Disabilities and Their Families: Teams and Teaming

I. Objectives

Participants will:

1. Describe the functions and structures of the team within early intervention.

2. Identify each of the professionals that may be included on a team and describe the role of each professional.

3. List at least three ways to facilitate equal participation of families as members of teams.

4. Describe typical team activities and identify the incentives and disincentives that relate to productive functioning of teams.

5. Describe the benefits of team participation for: (a) families, (b) professionals, and (c) children.

    [*Transparency 1*]

II. **OUTLINE**

A. Functions of Team Structures Within Early Intervention

1. Identification of Problems/Issues and Potential Solutions
   a. Refinement of Problem/Issue Statements Through Gathering of Additional Information
   b. Generation of Solutions to Problems/Issues

2. Implementation of Solutions to Problems/Issues
   a. Identification of Individual(s) Responsible for Implementing the Solution
   b. Development of a Plan for Delivery of the Solution

3. Monitoring of Effectiveness of Solutions in Addressing the Identified Problem/Issue
   a. Collection of Ongoing Data About the Effects of the Solution in Addressing the Identified Problem/Issue
   b. Periodic Review of Data to Evaluate the Effectiveness of the Solution.

4. Delivery of Solutions Until Problem/Issue is Addressed Fully and to the Satisfaction of a Family or Professional(s)
   a. Determine the Need to Adjust the Solution or its Delivery
   b. Deliver the Solution(s) Until the Point That the Problem/Issue is Fully Resolved

B. Team Structures Within Early Intervention

1. Labels and Descriptions of Team Structures
   a. Multidisciplinary
   b. Interdisciplinary
   c. Transdisciplinary (or Integrated)

2. Differences in Structure and Function Among Various Team Structures
    a. Interdisciplinary
    b. Multidisciplinary
    c. Transdisciplinary (or Integrated)

C. Professionals Likely to be Involved in Early Intervention Teams

1. Variety of Disciplines Dependent on Program Organization or, Ideally, on Child and Family Needs
2. Examples of Typical Professional Disciplines (e.g., Nurse, Physical Therapist, Early Interventionist, Speech/Language Pathologist, Psychologist)
3. Roles and Responsibilities of Typical Professionals

D. Facilitation of Equal Participation of Families as Members of Teams

1. Rationale and Reasons for Facilitating Participation
2. Benefits of Participation of Families as Equal Team Members
3. Strategies for Ensuring Equal Participation of Families in Team Membership

E. Typical Activities of Early Intervention Teams

1. Determination of Eligibility for Services
    a. Screening
    b. Evaluation
    c. Placement/Determination of Service Agency Involvement

2. Determination of Needs Through Assessment Activities
    a. Child Strengths and Needs
    b. Family Concerns, Priorities, and Resources

3. Provision of Coordinated Services
   a. Ongoing Provision of a Range of Services
   b. Coordination of Services Among Family and Professional Team Members

4. Periodic Evaluation of Child and Family Concerns

F. Incentives and Disincentives to Productive Team Functioning

   1. Incentives Such as Benefits to Child, Family, and Professional, Diminished Overlap of Services, Productive Communication, and Inter-Professional and Family-Professional Learning
   2. Disincentives Such as Limited Knowledge of How to Function as a Team Member, Non-Productive Communication About Team Members, Lack of Consensus on Team Focus or Direction, Difficulties With Role Release, Limited Time for Team Meetings, or Lack of Value for Team Structures by Administration

G. Benefits of Team Participation

   1. For Families
      a. Input Into Information Gathering
      b. Provision of Information About Their Child and Family
      c. Input Into Goal Setting Process
      d. Input Into Selection of Intervention Strategies
      e. Involvement and Investment in Child's Programming
      f. Potential Opportunity to Acquire New Knowledge and Skills

2. For Children
   a. Coordination of Services - Lack of Duplication
   b. Greater Achievement of Goals Possible

3. For Professionals
   a. Maximization of Services and Professional Input
   b. Shared Responsibility for Programming Success
   c. Capacity to Develop Integrated Interventions
   d. Possibility of Acquiring New Information and Skills by Working With Families and Other Disciplines in a Coordinated Team Structure

III. Explanatory Material/Expansion of Module Outline

A. Functions of Team Structures Within Early Intervention

General Information. The purpose of this section is to provide an overview of the functions of teams within early intervention. Teams are valued by professionals in early intervention settings and are strongly supported in early intervention legislation and regulations at the federal and state level.

This section should take approximately 5 - 10 minutes. Specifically, the instructor should focus the group on team structures as a whole (and as related to the particular discipline being taught). Most participants will be familiar with a concept of team (in schools, business, human services, medicine) and can use this knowledge as a basis for understanding the use of teams in early intervention programs.

Background. Teams are used within education, human services, and other fields, such as business, as a means of bringing and focusing various perspectives (and types of expertise) on identification and refinement of a problem or issue and on generating, implementing, and evaluating the effects of team solutions. Many regular elementary, middle, and high schools use teams in a variety of ways. Building teams, for example, focus a variety of perspectives (e.g., administration, teacher, parent, community resident) on decisions about the role, purpose, and functions of an individual school and, often, on the expenditure of funds within the school. A teacher, parent, and remedial reading teacher, for example, may focus joint energies on assisting a child to obtain effective reading skills. A group of third grade teachers may work together to team teach at the third grade level to promote quality instruction. Or, a special education and regular education teacher may work together to teach a kindergarten or elementary level classroom that includes children with and without disabilities. Persons who are receiving treatment in a rehabilitation program (e.g., cardiac, physical) may receive programming developed by a team of professionals.

Most teams perform similar functions whether located in businesses, schools, or medical settings. The composition of teams may differ in terms of the individuals who are members and their

expertise. Most teams, however, are structured to perform one or more of the following functions [*Transparency 2*]

- Identification of problems/issues and potential solutions.

- Implementation of solutions to problems/issues.

- Monitoring of effectiveness of solutions in addressing the identified problem or issue.

- Delivery of solutions until the problem or issue is addressed fully and to the satisfaction of a family, professional(s), or other individuals.

Examples. The instructor may perform one of several activities dependent upon knowledge and experience with teams and/or the group's experience with teams.

1. Provide an example of an issue (i.e., how to spend money allocated by a district to a particular school) and discuss solutions, the effects of solution, and delivery of solutions until a problem is resolved. For example, the principal may have a concern that the building needs repair, the teachers may be concerned about children's reading abilities, and the consumer may want to open the building at night in order to allow facilities to be used by the community. The instructor can provide examples of ways that the team identifies priority order of the concerns (e.g., votes, develops a long-range plan to address one or more issues in each of one or more years, negotiates to identify the focus for this year, etc.) as well as generates solutions for addressing the top concern. An example of a plan can be provided by the instructor (i.e., the team decides to focus on immediate building repair needs and on improving reading instruction and allocates 25% of the resources to repair and 75% to reading instruction). The team then makes decisions about strategies to address the concern about reading abilities by purchasing new reading materials, increasing the number of books in the library, etc. as well as assigns responsibility for each of the tasks (e.g., primary teachers meet and determine new books to be purchased for

instruction and for library lending, assigns one teacher to write up order and process). The primary teachers also evaluate current student performance, use materials, and determine the extent to which reading has improved. These solutions (e.g., purchased instructional and library materials) are effective when the problem has been resolved.

2. The instructor can select an issue relevant to the group being instructed or can allow the group to select an issue and follow through on each of the steps. Members of the group can be assigned specific roles/disciplines (e.g., principal, teacher, resource room teacher, parent) and can discuss the steps and their implementation. In a larger group, participants can be broken down into smaller groups of 4 to 5 people each and can take 5 minutes or so to work through an assigned issue. This same activity can be varied by selecting an issue, picking a small number of people from the group and having them role play various perspectives (e.g., administration; community; different professional disciplines, parents) in following the steps of team functions.

B.   Team Structures Within Early Intervention

<u>General Information</u>. The purpose of this section is to provide information about teams within early intervention. The structures of teams involved in the delivery of services may differ from program to program. The functions performed by teams follow the general functions described earlier but typically center on problems or issues with a particular child and family rather than upon problems or issues related to a program's organization, mission, or goals. Teams are likely to be composed of a number of different professional disciplines. The disciplines represented typically relate to the service delivery model, financial resources, availability of personnel, or primary service setting(s). For example, physicians are likely to be included as team members in medical diagnostic programs and less likely to be members of teams that operate from local educational agencies.

This section should take only 5-10 minutes. A primary aim is to focus on the differences and similarities among team structures as related to early intervention and focused upon problems or issues with young children and their families.

Background

1. **Labels and Descriptions of Team Structures**
[*Transparency 3 & 4*]

   a. **Multidisciplinary**

Different professionals separately evaluate child and family functioning, make recommendations, and establish goals and objectives, if necessary. Interventions are delivered typically by professionals in isolation from one another.

   b. **Interdisciplinary**

Different professionals separately evaluate child and family functioning but conduct a team meeting where team recommendations and goals and objectives are established.

   c. **Transdisciplinary - or Integrated Therapy**

Different professionals evaluate child and family functioning together, convene a team meeting, and determine recommendations and goals/objectives as a whole. One individual becomes responsible for delivering the intervention for all disciplines.

2. **Differences in Team Structure/Function**

   a. **Multidisciplinary**

A variety of different professionals individually evaluate a child's functioning for the purpose of: (a) describing current performance in a particular area such as speech, behavior, nutrition; (b) determining the extent to which performance is acceptable (i.e., developmentally appropriate) or is indicative of delays or dysfunction; and (c) providing services, if needed, that address the specific delay or dysfunction. Each discipline works separately from every other discipline but may refer a child or family for evaluation and services from another discipline. For example, a psychologist may determine that a family might benefit from counseling and would refer the child/family to social service. The social worker, in turn, would determine the need for services.

Family participation depends directly on the extent to which each professional involves the family in the evaluation or service provision process. The outcome of a multidisciplinary evaluation is: (a) individual discipline recommendations; and (b) if necessary, individual discipline intervention goals.

This team approach is most often used in medical settings or by physicians and related personnel.

b. Interdisciplinary

A variety of different professionals individually evaluate a child's functioning for the same purposes as in the multidisciplinary approach but, following the completion of the evaluation, all team members come together and discuss the results and make joint recommendations for needed services. **Each discipline works separately from every other discipline but brings information about current functioning, potential goals and objectives, and recommendations to a team meeting.** For example, a psychologist may determine that a child has a developmental delay in mental functioning, reports this information at the team meeting, and makes recommendations for needed services. The team then decides as a whole, the services that will be recommended by the group (team) collectively.

Family participation depends on involvement of families by each professional individually as well as on involvement at the team meeting. Ideally, family participation is promoted and supported by all team members so that families perform a role that is more expansive than simply listening to professional team member reports and recommendations. **The outcome of an interdisciplinary evaluation in early intervention is an Individualized Family Service Plan (IFSP), or an Individualized Education Program (IEP), or some other type of program planning document (e.g., IHP, IPP).**

This team approach is most often used in schools and rehabilitation settings.

c.   Transdisciplinary

A variety of different professionals evaluate a child from their professional perspective while in groups (two or more disciplines combined) or through the arena method of evaluation where one professional functions as a facilitator of child behavior and other professionals observe. Members of the team meet regularly to discuss and review child progress. Programming is delivered by one team member. This individual receives assistance and consultation from other members of the team, thereby expanding knowledge and skills and offering transdisciplinary services for the child and family.

Families are present during the evaluation and are encouraged to facilitate their children's best performance. The outcome of this team structure is a joint evaluation report, combining the information gathered by all disciplines, and jointly recommended goals and objectives. These may be reflected on any type of planning document.

This team approach is most often used in early intervention programs, in preschool programs, and, to some extent in school programs. Such an approach has been recommended widely to address the needs of individuals with severe disabilities and has been applied only occasionally with children with mild disabilities such as learning problems.

C.   Professionals Likely to be Involved in Early Intervention Teams [*Transparency 3*]

<u>General Information</u>. Early intervention programs vary in their organization and in the services provided. Some programs may provide only a visitor to the home while others may include physicians (usually as consultants), nurses, physical and occupational therapists, speech and language pathologists, and educators. The type of team approach used varies dependent upon the service model and staff available to a particular program. For the most part, the transdisciplinary or integrated team approach is recommended for early intervention programs.

This section should take approximately 5-10 minutes to demonstrate that team membership varies and may include a wide variety of professional disciplines.

1. Variety of Disciplines Dependent on Program Organization or Ideally, on Child and Family Needs

2. Examples of Typical Professional Disciplines

   Physical Therapist
   Occupational Therapist
   Educator (Early Interventionist; Early Intervention Specialist)
   Speech and Language Pathologist
   Nurses
   Physicians
   Nutritionists
   Psychologist
   Social Worker
   Family Therapist

3. Roles and Responsibilities [*Transparency 4*]

The overhead can be used to briefly outline the typical roles and responsibilities (areas of expertise) exclusive to each discipline.

D. Facilitation of Equal Participation of Families as Team Members

General Information. The purpose of this section is to allow participants to discuss the value and importance of including families as equal team members. Further, participants should be made to realize that family participation does not occur spontaneously but must be facilitated by professionals. Finally, participants are made aware of the types of strategies that can be used to facilitate participation.

This section should take approximately 10 minutes. Discussion and group identification can be used judiciously as this instructional method typically takes longer to cover than presenting information through straight lecture.

Background

1. **Rationale and Reasons for Facilitating Participation of Families (Why families may not spontaneously participate as equal team members)**

Families may be reluctant to share information in the presence of a large number of experts (i.e., may be intimidated).

The style by which information is presented by professionals may be intimidating or overwhelming. Families may feel that they have nothing further to contribute and/or that their observations are not of equal importance to those of the professionals.

Families may have had only brief acquaintance with the professionals and may not yet trust individuals sufficiently to provide information.

Families may not know what is important to contribute and may not want to inadvertently contribute information that makes then look "dumb" in the eyes of the professionals.

Language barriers may be present (e.g., professional terminology).

Previous experiences with professionals may have been unfavorable or negative.

2. **Benefits of Participation of Families as Equal Team Members**

Families who are knowledgeable about what activities will occur with their children and what services will be delivered - and who have a part in the decision making for their children - are likely to be more helpful to professionals (i.e., will carry out activities at home; will share responsibility for their children's progress and functioning), may have less stress in their lives, may be happier, and contribute time and expertise to the team's effort.

3. Strategies for Enhancing Family Participation

Strategies for enhancing family participation include:

- Allowing families to speak first in any meeting.

- Providing families with preparation for the meeting (i.e., explanations or "walk through" of what will happen during the meeting.)

- Using checklists or other planning documents to structure what families may want to bring up in a meeting are helpful for some families.

- Listening to family contributions to encourage ongoing communication.

- Structuring the physical environment (i.e., having the meeting table be round; holding the meeting in a family's home, if desired) makes everyone feel more comfortable and may set the "climate" for the meeting.

- Introducing all team members to the parent, having them explain who they are and the role they play(ed), and other similar activities to set the "social climate" for the meeting.

E. Typical Activities of Early Intervention Teams

General Background. The purpose of this section is to describe briefly the types of activities that are typical of teams in early intervention program settings. These include: (a) determination of a child's eligibility for service(s), (b) identification of a child's needs and the needs of the family, and (c) provision of coordinated services.

This section should take approximately 10 minutes.

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Background

1. Determination of Eligibility for Services

Determination of eligibility for services may be accomplished by a team whose purpose is evaluation or placement but which will not be responsible for children's programming if services are needed. In other situations, the same team that determines eligibility will provide early intervention services, also.

Eligibility criteria for early intervention services vary on a state by state basis but include categories of established risk (for example, a child with Down syndrome) and delayed development. Children may be required to demonstrate substantial delays in more than one area of development. Five areas of development are investigated:
(a) communication; (b) social or emotional; (c) adaptive; (d) physical (including vision, hearing, and health); and (e) cognitive.

Teams may perform three functions in determining eligibility:
(a) screening, (b) comprehensive evaluation, and (c) determination of placement. **Screening** involves one or more professional team members who use particular assessment devices (such as the **Denver Developmental Screening Test**) to determine the need for further evaluation. Screening is carried out in settings such as Well Baby Clinics, Neonatal Follow-Up Clinics, or as part of tracking systems of high risk infants.

Comprehensive Evaluations are conducted to determine the extent of a child's developmental delays and to identify the areas in which those delays are present. These evaluations may be conducted separately by one or more disciplines (as in the Multidisciplinary or Interdisciplinary approaches) or by a team of professionals together (as in the Transdisciplinary or Integrated approach). Ideally, parents provide information about their children that is included in the comprehensive evaluation. This information may be provided by a parent, verbally, or through completion of checklists or general questionnaires which ask families to provide specific information about their children.

The **Comprehensive Evaluation** provides the basis for making recommendations for placement within particular service programs. If

a child's present level of development indicates delays (typically in one or more areas of development), recommendations would be made for placement within the early intervention service system or for particular early intervention services.

2. Determination of Needs Through Assessment Activities

A variety of approaches can be taken by one or more team members, including parents, to determine the needs of the child and family as well as the family's priorities, concerns, and resources. The purpose of the assessment phase is to identify the specific outcomes that will be included on the individual plan being used within the early intervention program. The **Individualized Family Service Plan (IFSP)** is required to be used in state-wide early intervention programs. This plan includes outcomes that are established by families or are established by individual team members or the team as a whole.

Team members roles in the assessment phase is to provide ongoing data about children that will help provide them with services necessary to achieve the desired outcomes. Therefore, team members are likely to observe children in a variety of settings (including home, program, community) or use a variety of structured observational techniques such as play assessment procedures or ecological inventories. Standardized tests of development that require children to perform specific test items within contrived settings (such as clinic testing offices) are more likely to be used in the eligibility determination than as data in deciding the services and instructional methods needed by a child.

Assessment of family concerns, priorities, and resources is conducted, ideally, in ways that the parents prefer to give information and on a voluntary basis. Information from families may be obtained by having families tell stories about their children, participate in structured or unstructured interviews, or complete written checklists or questionnaires. Of primary importance in assessment of family concerns, priorities, and resources is that the process must be voluntary and information must be obtained in ways that reflect family preferences. All families are not comfortable verbally sharing information about their lives and many families are not interested in reading and filling out lengthy forms. The assessment procedures used

by a team should be flexible enough to allow individualization for family values, culture, and preferences.

3. Provision of Coordinated Services

Team members provide services, as outlined on the IFSP (or other program plan) in locations determined as appropriate for the child and family. Team members may provide services in the child's home, family or center day care, relative's house, hospital, or any other location that is most convenient for the family. In all instances, services are provided in the environments where typical children of the same age would be found.

Children may receive individual services (e.g., individual physical therapy), services within the context of a group (e.g., facilitation of language skills within the local library preschool story hour) or group early intervention programming (e.g., parent-infant toddler groups). Children may receive only one early intervention service (e.g., social work) or may receive services from one or more professional disciplines. The number of services, the location(s) in which they will be provided, their length (e.g., 45 minutes), intensity (e.g., twice per week), and duration (e.g., for 12 months) are determined by the team and written on the IFSP.

Infants, toddlers, and their families may require any number of services that may be provided by one or more agencies. For example, a child may receive home nursing services, home-based physical therapy, respite care services, and go to the local YWCA parent-infant program for socialization. The child's family may participate in a local parent support group and attend CPR classes. Such situations require coordination among professionals and among agencies. In a sense, these situations require the formation of teams of individuals who are employed by a variety of health, social service, community, educational, and early intervention agencies. Coordination among disciplines and among agencies is needed in order to ensure that all the needs of the child and concerns of the family are appropriately addressed.

One team member may assume the role of service coordinator (or case manager) or an individual may be employed to serve only as the service coordinator. A family member may share in the service

coordination responsibilities or may assume full responsibility, dependent on the parent's preference. The purpose of service coordination is to provide families information, access them to services easily, and ensure that information is shared among service providers - within and across agencies.

4. Periodic Evaluation [*Transparency 8*]

Periodic evaluation is performed by parents with the service coordinator, individual team members, or the team, as a whole. Team members review the child and family plan on a periodic basis and at least twice annually. The criteria used for determination of outcome vary. Transparency 8 includes an example of a scoring system used by families to determine the status of particular outcomes.

F. Incentives and Disincentives

<u>General Background</u>. This section is best addressed through group discussion (if time permits). The focus is to get the group to identify incentives and disincentives.

This information may be presented in approximately 5 minutes by outlining typical incentives/disincentives and asking the group to identify which are most important or to generate other possibilities not included on the list.

<u>Background</u>. Effective, productive, and goal-oriented teams occur when the individuals who are team members are committed to making the team process beneficial. Many factors function as incentives for team members but many factors function, also, as disincentives for productive team functioning. These factors may be generated by the group or listed by the instructor.

1. Incentives [*Transparency 9*]

Incentives for professionals and families include: (a) learning information that has not previously been learned, (b) coordination in approaching particular learning targets, (c) diminished overlap of services, and (d) other factors.

2. Disincentives [*Transparency 10*]

Disincentives include: (a) limited (or lack of) knowledge about how to best serve as a team member, (b) lack of consensus on team purpose, and (c) other factors.

G. Benefits of Team Participation

<u>General Information</u>. The purpose of this section is to end the presentation (and module) positively to focus participants on the benefits of team participation for all participants (e.g., professional; family; child).

The information can be presented in discussion (if time permits) where the group is asked to problem solve the benefits or by using the case history handout which the instructor reads for the class and has the class determine the benefits in this particular situation. These benefits may be listed on a blackboard or overhead. If the group has difficulty identifying the benefits, [*Transparency 11*] can be used and participants can identify whether or not each listed factor represents a benefit or whom the factor benefits.

This information should take about 10 minutes dependent on the form of presentation used.

<u>Background</u>. Team programming is very popular in early intervention programs. Team delivered evaluation, assessment, and service provision are mandated in most legislation that directs provision of early intervention, educational, or other services for children with disabilities. The models discussed in this module are all used in various settings and services attended by young children. The transdisciplinary or integrated approach is the most popular in early intervention programs.

These team approaches benefit everyone -- professionals, families, and children -- when everyone works together to use the team structure effectively and productively.

Parents learn about: resources and services in which they, their families, or their children may participate; the needs of their child with

a disability; activities that may enhance their child's participation at home and in the community.

Children benefit in that many different perspectives (and bodies of information) may be directed toward enhancing their participation; children **may** have greater opportunities when all effort is directed collectively toward their and their families' needs.

Professionals learn about: family values; children's functioning in settings where performance cannot be directly observed; family priorities, needs, and concerns; the "personality" of the child.

IV. Evaluation

The case history may be used, also, as an evaluation tool by asking one or more of the following questions:

1. What was the purpose of Sarah's evaluation from the standpoint of the professionals and from the standpoint of Sarah's mother Erika?

2. What were the results of the evaluation?

3. What type of team structure was used for the evaluation?

4. How will the professional and family team members address the family's priorities, concerns, and resources?

CASE HISTORY
THE GONZALEZ FAMILY

Child: Sarah (aged 8 months)

Other Children: Jose (aged 19 months)

                    Erika (age 34 months)

Parents: Erika (mother is 19 years old)

                    Jesus Ribaldo (father of Jose and
                    Sarah, is 21 years old)

Situation:

Erika has taken Sarah to the local hospital emergency room because Sarah seemed to be shaking (which frightened her mother). The physician at the emergency room determined that Sarah had a seizure secondary to a very high fever but recommended that Erika return with Sarah to the outpatient clinic to have a developmental evaluation.

Erika missed three appointments before she returned with Sarah (at the age of 8 months) to the clinic. The other children accompanied the mother. The team of professionals included: developmental pediatrician, occupational therapist, physical therapist, speech pathologist, psychologist, social worker, nurse, and educator. They asked Erika what her concerns were about Sarah and Erika answered that the baby smiled a lot and was happy and had adjusted to home reasonably well. She said she thought the baby was doing well considering her birth history.

The team conducted an evaluation where one person (the nurse) handled Sarah and facilitated performance in a variety of areas. Other team members looked on and observed performance in their areas. Sarah was fussy and did not seem to perform to full capacity. Her

mother facilitated Sarah by playing with her with her favorite toys. At the end of the time, the mother and all the professionals sat down to determine any needed services for Sarah and her family.

The team decided that:

1. Sarah could use stimulation in her home by a home visitor on a once per week basis.

2. Erika could use some respite care in order to be able to get out of the house. The social worker would apply for respite care program with Erika.

3. The older children might attend Head Start or another neighborhood program. Erika did feel that her daughter Erika was old enough but felt that Jose was too young.

4. The family qualified for the WIC program of which Erika had not been aware. Enrollment would provide the family with more resources.

5. Erika expressed a desire to finish high school.

6. Erika expressed a desire for Sarah to be less fussy at home and easier to know what she wanted and to get her to stop crying. She expressed concern since the baby's father seemed to have little tolerance for the crying and even less tolerance for the mother's ability to calm the infant. The mother discussed some of the things (slow rocking) that did calm the baby but said that they did not work all of the time.

V. Suggested References

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Association for the Care of Children's Health and NEC*TAS.

INSTRUCTIONAL MODULE III

Infants and Toddlers With Disabilities and Their Families:

Teams and Teaming

PART TWO

Supporting Materials

I.   Lecture Notes
II.   Student Handout for Note-Taking
III.   Additional Student Handouts
IV.   Transparency Samples

Faculty Presentation Guide

> **Infants & Toddlers with Special Needs and Their Families**
>
> **Teams & Teaming**
>
> LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Faculty Presentation Guide

Objectives

Participants will be able to:

✔ Describe the functions and structures of the team within early intervention.

✔ Identify each of the professionals that may be included on a team and describe the role of each professional.

✔ List at least three ways to facilitate equal participation of families as members of teams.

✔ Describe typical team activities and identify the incentives and disincentives that relate to productive functioning of teams.

✔ Describe the benefits of team participation for: (a) families; (b) professionals; and (c) children.

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Team Transparency # 2

Functions of
Teams

✓ Identification of problems/issues
and potential solutions

✓ Implementation of solutions to
problems/issues

✓ Monitoring of effectiveness of
solutions in addressing the
identified problem or issue

✓ Delivery of solutions until the
problem/issue is addressed fully
and to the satisfaction of a family,
professional(s), or other individual

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

Teams Transparency # 3

Definitions Of Team Structures

TEAM	EVALUATION FUNCTION	PLANNING FUNCTION	INTERVENTION FUNCTION
MULTI-DISCIPLINARY	INDIVIDUAL DISCIPLINE EVALUATIONS	INDIVIDUAL RECOMMEN-DATIONS	INDIVIDUAL INTERVENTIONS
INTER-DISCIPLINARY	INDIVIDUAL DISCIPLINE EVALUATIONS	TEAM MEETING THAT RESULTS IN INDIVIDUAL AND JOINT REC-OMMENDATIONS	INDIVIDUAL OR JOINTLY CONDUCTED INTERVENTIONS (INTEGRATED)

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Lecture Notes

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Faculty Presentation Guide

Definitions Of Team Structures, cont'd

TEAM	EVALUATION FUNCTION	PLANNING FUNCTION	INTERVENTION FUNCTION
TRANS-DISCIPLINARY	JOINT OR ARENA EVALUATIONS	TEAM MEETINGS WITH JOINT REC-OMMENDATION	ONE DISCIPLINE (TEAM MEMBER) IMPLEMENTS ALL INTERVENTIONS; OTHER TEAM MEMBERS SERVE AS CONSULTANTS TO PRIMARY INTERVENOR

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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Faculty Presentation Guide

Team Transparency # 5

Typical Disciplines On Early Intervention Teams

✓ Physical Therapist

✓ Occupational Therapist

✓ Early Interventionist (Teacher)

✓ Speech and Language Pathologist

✓ Adapted Physical Educator

✓ Nutritionist/Dietician

✓ Psychologist

✓ Social Worker

✓ Nurse

✓ Physician

✓ Audiologist

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Lecture Notes

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Faculty Presentation Guide

Expertise Of Various
Professional Disciplines

Discipline	Areas of Expertise
Physical or Occupational Therapist	Motor abilities (gross motor & coordination); Self-Care Skills; Sensory & Motor abilities
Early Interventionist (Teacher)	Cognitive, play, social interaction skills
Speech and Language Pathologist	Speech and language abilities; augmentative communication
Adapted Physical Educator	Motor abilities; adaptive and self-help skills
Nutritionists/Dieticians	Nutritional status and nutritional counseling

LA SICC Personnel Preparation Subcommittee, 1991

Lecture Notes

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Teams Transparency # 7

Expertise Of Various
Professional Disciplines, cont'd

Discipline	Areas of Expertise
Psychologist	Cognitive abilities and adaptive behavior; social-emotional abilities
Social Worker	Family and child functioning and emotional well-being
Nurse	Medical status including administration of specific procedures and drugs
Physician.	Evaluation and diagnosis of the child's disability (as a whole) or of specific issues (e.g., ears, eyes, neurology).
Audiologist	Hearing; assistive devices

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Lecture Notes

Faculty Presentation Guide

Evaluation Scale

1. Goal met or no longer a need

2. Outcome accomplished - not to family's satisfaction

3. Outcome partially accomplished

4. Situation unchanged; still a need

5. Modifications of outcomes or services are needed

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Lecture Notes

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Faculty
Presentation
Guide

Examples Of Incentives That Support Productive Team Functioning

✔ Benefits to professionals, children, and families

✔ Diminished overlap of services

✔ Communication among team members leading to better performance of children

✔ Ability to learn new information through interaction with families and other professionals

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Lecture Notes

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Faculty Presentation Guide

Examples Of Disincentives That Counteract Effective Team Functioning

✔ Inability to function as a team member (poor group skills)

✔ Inexperience in negotiation and other necessary group skills

✔ Non-productive communication about children, families, and other professionals

✔ Lack of consensus on team purpose, mission, or on child focus

✔ Limited time for meetings and discussion

✔ Limited time to work together with a child and family

✔ Administration does not value the importance of the team and does not administratively support team members

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Lecture Notes

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Faculty Presentation Guide

Team Transparency # 11

Benefits Of Teaming

_____ Input into information gathering

_____ Coordination of service - lack of duplication

_____ Acquisition of new information and skills

_____ Greater possible achievement of goals

_____ Capacity to develop integrated interventions

_____ Input into selection of intervention strategies

_____ Investment in the child's programming

(Mark the slot with "F" (family); "P" (professional); and "C" (child) to indicate the person(s) most likely to achieve the listed benefit.

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Lecture Notes

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Infants & Toddlers with Special Needs and Their Families

Teams & Teaming

Objectives

Participants will be able to:

- [content illegible]
- [content illegible]
- [content illegible]
- [content illegible]
- [content illegible]

Functions of Teams

- Identification of problems/issues and potential solutions
- Implementation of solutions to problems/issues
- Monitoring of effectiveness of solutions in addressing the identified problem or issue
- Delivery of solutions until the problem/issue is addressed fully and to the satisfaction of a family, professional(s), or other individual

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Teams Transparency #3

Definitions Of Team Structures

TEAM	EVALUATION FUNCTION	PLANNING FUNCTION	INTERVENTION FUNCTION
MULTI-DISCIPLINARY	INDIVIDUAL DISCIPLINE EVALUATIONS	INDIVIDUAL RECOMMEN-DATIONS	INDIVIDUAL INTERVENTIONS
INTER-DISCIPLINARY	INDIVIDUAL DISCIPLINE EVALUATIONS	TEAM MEETING THAT RESULTS IN INDIVIDUAL AND JOINT REC-OMMENDATIONS	INDIVIDUAL OR JOINTLY CONDUCTED INTERVENTIONS (INTEGRATED)

Team Transparency #4

Definitions Of Team Structures, cont'd

TEAM	EVALUATION FUNCTION	PLANNING FUNCTION	INTERVENTION FUNCTION
TRANS-DISCIPLINARY	JOINT OR ARENA EVALUATIONS	TEAM MEETINGS WITH JOINT REC-OMMENDATION	ONE DISCIPLINE (TEAM MEMBER) IMPLEMENTS ALL INTERVENTIONS; OTHER TEAM MEMBERS SERVE AS CONSULTANTS TO PRIMARY INTERVENOR

Team Transparency #5

Typical Disciplines On Early Intervention Teams

✓ Physical Therapist

✓ Occupational Therapist

✓ Early Intervention (Teacher)

✓ Speech and Language Pathologist

✓ Adapted Physical Educator

✓ Administrator/Director

✓ Psychologist

✓ Social Worker

✓ Nurse

✓ Physician

✓ Audiologist

Team Transparency # 6

Expertise Of Various
Professional Disciplines

Discipline	Areas of Expertise
Physical or Occupational Therapist	Motor abilities (gross motor & coordination); Self-Care Skills; Sensory & Motor abilities
Early Interventionist (Teacher)	Cognitive, play, social interaction skills
Speech and Language Pathologist	Speech and language abilities; augmentative communication
Adapted Physical Educator	Motor abilities; adaptive and self-help skills
Nutritionists/Dieticians	Nutritional status and nutritional counseling

Teams Transparency # 7

Expertise Of Various
Professional Disciplines, cont'd

Discipline	Areas of Expertise
Psychologist	Cognitive abilities and adaptive behavior; social-emotional abilities
Social Worker	Family and child functioning and emotional well-being
Nurse	Medical status including administration of specific procedures and drugs
Physician	Evaluation and diagnosis of the child's disability (as a whole) or of specific issues (e.g., ears, eyes, neurology)
Audiologist	Hearing; assistive devices

Team Transparency #8

Evaluation Scale

1. Goal met or no longer a need

2. Outcome accomplished - not to family's satisfaction

3. Outcome partially accomplished

4. Situation unchanged; still a need

5. Modifications of outcomes or services are needed

Team Transparency #9

Examples Of Incentives That Support Productive Team Functioning

✔ Benefits to professionals, children, and families

✔ Diminished overlap of services

✔ Communication among team members leading to better performance of children

✔ Ability to learn new information through interaction with families and other professionals

Team Transparency #10

Examples Of Disincentives That Constrict Effective Team Functioning

✔ Inability to function as a team member (poor group skills)

✔ Impatience in negotiation and other necessary group skills

✔ Non-productive communication about children, families and other professionals

✔ Lack of consensus on team purpose, mission, or on child focus

✔ Limited time for meetings and discussion

✔ Limited time to work together with the child and family

✔ Administration does not value the importance of the team and does not administratively support team members

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Objectives

Participants will be able to:

✔ Describe the functions and structures of the team within early intervention.

✔ Identify each of the professionals that may be included on a team and describe the role of each professional.

✔ List at least three ways to facilitate equal participation of families as members of teams.

✔ Describe typical team activities and identify the incentives and disincentives that relate to productive functioning of teams.

✔ Describe the benefits of team participation for: (a) families; (b) professionals; and (c) children.

LA SICC Personnel Preparation Subcommittee, 1991

Functions of Teams

✓ Identification of problems/issues and potential solutions

✓ Implementation of solutions to problems/issues

✓ Monitoring of effectiveness of solutions in addressing the identified problem or issue

✓ Delivery of solutions until the problem/issue is addressed fully and to the satisfaction of a family, professional(s), or other individual

LA SICC Personnel Preparation Subcommittee, 1991

Definitions Of Team Structures

TEAM	EVALUATION FUNCTION	PLANNING FUNCTION	INTERVENTION FUNCTION
MULTI-DISCIPLINARY	INDIVIDUAL DISCIPLINE EVALUATIONS	INDIVIDUAL RECOMMEN-DATIONS	INDIVIDUAL INTERVENTIONS
INTER-DISCIPLINARY	INDIVIDUAL DISCIPLINE EVALUATIONS	TEAM MEETING THAT RESULTS IN INDIVIDUAL AND JOINT REC-OMMENDATIONS	INDIVIDUAL OR JOINTLY CONDUCTED INTERVENTIONS (INTEGRATED)

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LA SICC Personnel Preparation Subcommittee, 1991

Definitions Of Team Structures, cont'd

TEAM	EVALUATION FUNCTION	PLANNING FUNCTION	INTERVENTION FUNCTION
TRANS-DISCIPLINARY	JOINT OR ARENA EVALUATIONS	TEAM MEETINGS WITH JOINT REC-OMMENDATION	ONE DISCIPLINE (TEAM MEMBER) IMPLEMENTS ALL INTERVENTIONS; OTHER TEAM MEMBERS SERVE AS CONSULTANTS TO PRIMARY INTERVENOR

430

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Typical Disciplines On Early Intervention Teams

✓ Physical Therapist

✓ Occupational Therapist

✓ Early Interventionist (Teacher)

✓ Speech and Language Pathologist

✓ Adapted Physical Educator

✓ Nutritionist/Dietician

✓ Psychologist

✓ Social Worker

✓ Nurse

✓ Physician

✓ Audiologist

LA SICC Personnel Preparation Subcommittee, 1991

Expertise Of Various Professional Disciplines

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LA SICC Personnel Preparation Subcommittee, 1991

Expertise Of Various Professional Disciplines, cont'd

Discipline	Areas of Expertise
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Audiologist	Hearing; assistive devices

435

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LA SICC Personnel Preparation Subcommittee, 1991

Examples Of Incentives That Support Productive Team Functioning

✔ **Benefits to professionals, children, and families**

✔ **Diminished overlap of services**

✔ **Communication among team members leading to better performance of children**

✔ **Ability to learn new information through interaction with families and other professionals**

LA SICC Personnel Preparation Subcommittee, 1991

Examples Of Disincentives That Counteract Effective Team Functioning

✔ Inability to function as a team member (poor group skills)

✔ Inexperience in negotiation and other necessary group skills

✔ Non-productive communication about children, families, and other professionals

✔ Lack of consensus on team purpose, mission, or on child focus

✔ Limited time for meetings and discussion

✔ Limited time to work together with a child and family

✔ Administration does not value the importance of the team and does not administratively support team members

LA SICC Personnel Preparation Subcommittee, 1991

Benefits Of Teaming

_____ **Input into information gathering**

_____ **Coordination of service - lack of duplication**

_____ **Acquisition of new information and skills**

_____ **Greater possible achievement of goals**

_____ **Capacity to develop integrated interventions**

_____ **Input into selection of intervention strategies**

_____ **Investment in the child's programming**

(Mark the slot with "F" (family); "P" (professional); and "C" (child) to indicate the person(s) most likely to achieve the listed benefit.

LA SICC Personnel Preparation Subcommittee, 1991

Infants and Toddlers With Special Needs and Their Families

Collaboration

Instructional Module

Infants and Toddlers with Disabilities and Their Families:

Collaboration

PART ONE

I.   Objectives
II.   Outline
III. Explanatory Materials
IV.   Evaluation
V.   Resource Material

Instructional Module

Infants and Toddlers with Disabilities and Their Families: Collaboration

I. Objectives

Participant will be able to:

A. Provide a rationale for collaboration in early intervention

B. Describe barriers to collaboration

C. Describe ways in which individuals manage conflict during collaboration

D. Identify the types of conflict management style used by an individual

E. Describe ways to resolve conflict

II. Outline

A   Rationale for collaboration

    1.   Improvement of service delivery

    2.   Reduction in service duplication

    3.   Links among families and professionals for efficient service utilization

B   Conflict management styles: benefits and drawbacks

    1   Competitive

    2.   Avoidance

    3.   Accommodating

    4.   Compromising

    5.   Collaborative

    6.   Activity - How do I mange conflict?

C.   Barriers to collaboration

    1.   Competitiveness between agencies

    2.   Lack of organizational structure for coordination

    3   Technical factors

    4   Personnel

D.   Methods for resolving conflict

    1.   Steps for addressing conflict

        A.   Clarify issues objectively

        B.   Set expectations and outcomes

        C.   Communicate clearly

        D.   Use a variety of strategies

     i.   Problem solving

     ii.   Brainstorming

     iii.   Selecting from options

     iv.   Negotiation

2.   Negotiation strategies

    A.   Separate the people from the problem

    B.   Focus on mutual interests

    C.   Invent options and alternatives for mutual gain

    D.   Manage anger and resistance

    E.   Insist on using objective criteria

    F.   Select options and alternatives

3.   Activity - How well do you negotiate?

III. Explanatory Materials/Expansion of Module Outline

A. Rationale for Collaboration [Transparency 1]

The development of cooperative arrangements among professionals is a common strategy that has been used to improve service delivery (Shenet, 1982). Cooperative arrangements are required by many federal laws, and the desired outcome is the development of more effective interagency agreements. Part H of The Education of the Handicapped Act Amendments of 1986, P.L. 99-457, stipulates that children with disabilities receive "coordinated, comprehensive, multidisciplinary, interagency" services. To ensure that the needs of children with disabilities and their families are being met, it is essential that professionals involved in early intervention learn and develop techniques for developing successful cooperative relations for service delivery. This is because cooperating agencies maintain their own autonomy, as well as their own philosophy and service goals, and these may not be appropriate for the target population. Professionals in the fields of medicine, service coordination, education and social services have all been trained to provide technical expertise in their area of specialty, but few have been taught how to function with other professionals as members of a team. Unfortunately, this model tends to drive most initial attempts to organize services for young children with disabilities and their families.

In order to improve this situation, it has been suggested that the focus of interagency models should shift from cooperative arrangements among agencies to collaborations focused on joint service delivery. It is generally agreed that children with disabilities benefit from the combined expertise of various professionals. Collaboration is a method for blending knowledge from many sources, and has been proven successful in developing comprehensive and coordinated family-centered services. A collaborative strategy is called for in communities where the need and intent is to fundamentally change the way services are designed and delivered (Melaville & Blank, 1991). This requires that the involved agencies agree on a common philosophy and service goal that can only be achieved through joint agency activities. Part H of IDEA assists agencies in moving toward this model by embodying a philosophy of a service delivery system composed of 14 components that can only be achieved through the adoption of such activities (Trohanis, 1989).

There are many benefits to collaborative service delivery models (Elder & Magab, 1980), the most important being an improvement in service delivery to those it serves. Improved services are the result of more efficient and effective use of services, providers, and funding streams across agencies (Audette, 1980; Bailey, 1984). Collaboration also results in the reduction of service duplication (Garland & Linder, 1988; Healy, Keesee, & Smith, 1989), Lastly, collaborative efforts enable parents and service providers to efficiently locate and manage the services required by their family (Bailey, 1989a; Dunst & Trivette, 1988).

B.   Conflict Management Styles: Benefits and Drawbacks [Transparency 2]

Collaborative early intervention service systems remain an elusive goal for many states. Yet, the mere recognition of the benefits has not resulted in effective collaborations. Fragmented and isolated services continue to occur by default, rather than by choice, because professionals have not had the opportunity to learn and practice alternative ways of working together (Rainforth, 1990). As a result, professionals and agencies often find themselves in conflict. Conflict is any situation in which one person or group perceives that another person or group is interfering with his or her goal attainment. People tend to approach conflict in a variety of ways. There are five common styles of conflict management, each of which has benefits and drawbacks. The style of conflict management used in a situation often depends on the content and context of the issue.

1.   Competitive [Transparency 3]

One style of conflict management is the competitive style. This style is characteristic of people who tend to overpower others with whom they have a conflict. Their goal is to win, regardless of possible negative repercussions. This may be a very appropriate style to utilize when there are ethical concerns or when one is certain they are right. However, some pitfalls of the competitive style are that others may stop engaging in meaningful interactions and collaborative relations can be seriously inhibited or destroyed.

2.   Avoidance [Transparency 4]

Avoidance is a second style of conflict management in which people try to avoid conflict by ignoring discrepancies between their own goals and those of others. When conflict is emotionally laden and participants need

time to regain their composure, avoidance may be a very appropriate and sensitive methods for handling conflict. However, this approach can give a false sense that all is well. By not addressing the issue head on, conflict can continue to plague the group and may escalate as the result of inaction.

3.   Accommodating   [Transparency 5]

People who put aside their own needs in order to ensure that others needs are met are engaging in an accommodating style of conflict management. Accommodating is appropriate when the conflict is relatively unimportant or when you are unable to alter the situation of another. The negative ramifications however, can prove very frustrating. Frequent accommodation may result in others devaluing your ideas over time and may cause you to feel that others are taking advantage of you.

4.   Compromising [Transparency 6]

A less surrendering style of conflict management is compromising. In the compromising style, people give up some on an issue while asking others to do the same. This can be a very useful approach when there is deadlock over an issue. Although a benefit of this style is that the end result is usually acceptable to all, compromising falls short of meeting the needs of all.

5.   Collaborative [Transparency 7]

Certainly the most desirable style of conflict management is collaborative problem solving. In this style people utilize a high degree of both assertion and cooperation. Although the collaborative style tends to be time consuming and requires a trusting rapport among professionals, the benefits are new and creative solutions to problems. The collaborative process requires that all members clarify the issues and commonly determine the goals. This shared commitment of collaboration results in less conflict and greater satisfaction for those involved.

6.   Activity [Handout 1]

How do I manage conflict? Use the Thomas Kilmann Questionnaire to see what kind of strategies you use to manage conflict.

C. Barriers to Collaboration [Transparency 8]

Though collaboration may not always be possible, it is certainly the most desirable style for professionals from various disciplines to interact with one another. A more favorable climate for collaboration occurs when agencies, programs or groups share a common philosophy and goal, and the service delivery issue is a priority for each of the service agencies. However, there are several barriers to implementing interagency collaboration. For example, not all participating agencies may agree on the necessity for service improvements. There may be other priorities influencing agencies, such as a budget shortfall, or agencies may already have a history of competition or negative relationships. Nevertheless, federal legislation has clearly created a need to prioritize collaboration, which should facilitate the development of a favorable climate for change to occur.

1   Competitiveness Between Agencies [Transparency 9]

One barrier to interagency collaboration is competitiveness between agencies. Competition between agencies often exists over clients and services. Frequently, the conflicts result from a lack of accurate information about the functions of other agencies. Each agency and program entering into an interagency collaboration has a set of rules and regulations that stipulates target population, budgetary operations, and service structure (including staffing patterns). Agencies and programs must be prepared to share these policies with each other so that barriers to interdependent functioning can be identified and removed. Many existing agency and program policies will need to be evaluated and refined in order to comply with the collaborative requirements of Part H.

2.   Lack of Organizational Structure for Coordination [Transparency 10]

Another barrier results from the lack of organizational structure for facilitating coordination between agencies. The goals and philosophies of each agency are individually established. Therefore, existing agency structures are not conducive to jointly planning, teaming, and implementing decisions in a cooperative and coordinated manner. Interagency collaboration requires a process of establishing goals and objectives, clarifying roles, making decisions, and resolving conflicts. The first step

necessary for collaborative arrangements to occur is the adoption of a common vision by all involved in the service delivery system. Part H of IDEA ensures that this will occur, because the legislation defines the vision for a collaborative statewide early intervention program. One difficulty in establishing this vision across the various agencies and programs involved in early intervention may be their differing interpretations of the adequacy of the existing system. This obstacle can only be overcome when all participants are willing to participate in a process to ensure open, continued communication, negotiations, and conflict management.

3 Technical Factors [Transparency 11]

Technical factors also interfere with interagency collaboration. Scarce resources of staff, time and money are factors that inhibit agencies from exerting the time and effort to collaborate with other agencies. Logistical issues, such as distance and geography, are common excuses for agencies to not work collaboratively. Interagency collaborative efforts require new fiscal arrangements to ensure the development and delivery of services. Resources of all kinds (fiscal, staff, time, in-kind services) will have to be pooled to establish the most efficient system for delivery of services. In an age of shrinking resources, interagency collaborations are often the only way to guarantee the development of an integrated service system. Early intervention is one area in which resources must be pooled and funding levels increased. Only then will states be able to implement services in conjunction with the spirit of Part H.

4. Personnel [Transparency 12]

As in any situation, the attitudes of personnel can present the greatest barrier to interagency collaboration. Individuals who are resistant to change will find many reasons why collaboration between agencies cannot occur. Frequently, such resistance is indicative of a lack of commitment to the more global needs of children and families, a failure to acknowledge the strengths of other disciplines, or a lack of support from administrative powers. The people involved in the creation, development, and implementation of the interagency service system are a critical factor in the ultimate success of the collaborative model. Most important is an effective leader. A leader must be able to both establish and help sell the vision to all participants. He or she must also be able to translate the vision into the reality of service delivery. Also important is the competence and commitment of the other participants, both to policymaking and service

delivery. All participants should be provided access to support and training as their roles change with the development and implementation of a collaborative service delivery system.

D. Methods for Resolving Conflict

Resolution of conflicting goals, philosophies, and objectives is the foundation for building collaborative relationships between agencies. By following prescribed steps to achieve collaboration, shared commitment and responsibility are the natural by product that result from the process. The steps involved require members of interagency teams to share not only their knowledge and expertise, but also their expectations. When entering into interagency collaborations, it is effective to have some agreed upon guidelines that will be followed when conflicts arise. These guidelines should designate the steps the group will take to resolve conflict and the process by which any negotiation of ideas will be conducted.

1. Steps for Addressing Conflict [Transparency 13]

Conflict can often be avoided or quickly diffused by adhering to a defined process. First, all members should participate in clarifying the issues. Once the issues have been defined, the expectations and outcomes should be set and agreed upon by everyone involved. This requires clear and open communication. When conflicting attitudes exist, strategies can be used to stimulate new alternatives and options. Among these strategies are problem solving, brainstorming new options, selecting from among new options, and if consensus cannot be attained, engaging in negotiations.

2. Negotiation Strategies [Transparency 14]

Effective negotiations can generate amenable solutions to conflicts. However, to keep negotiations productive and on track, the following must occur.

- Separate the people from the issues, so that the appropriate focus is maintained.

- Concentrate on areas of mutual interest, to stimulate additional areas of mutual concern and agreement.

- Suggest new options and alternatives that would prove mutually beneficial.

- Carefully control anger and resistance so that the process is not hindered further.

- Be sure to use objective criteria for making decisions and achieving consensus.

- Use newly offered alternatives to find a solution that may be commonly agreed upon and accepted.

A positive atmosphere of communication and trust among the participants must be maintained throughout the interagency collaborative process (Johnson & Johnson, 1987). This occurs when the focus of the collaboration is on the people involved, rather than on the individual agency and program requirements (Fisher & Brown, 1989). This focus should include both the consumers of the services (families and children) and the service providers. The collaborative vision can be defined as "relationship driven," as the participants focus on improving the services or system for people, rather than for agencies and programs. The end result of developing these qualities is that of increased problem solving for the team and a common desire to find mutually beneficial solutions. This collaborative model is at the very heart of early intervention under Part H of IDEA.

3.   Activity [Handout 2]

Use this Dr. Chester L. Karrass' self evaluation checklist to determine how well you negotiate.

To evaluate yourself, check the answer key and add your positive and negative scores separately. Subtract them from each other.

A score between +250 and +340 indicates you are probably negotiating well already. The range of +180 to +250 suggests you have a good measure of the qualities it takes to negotiate successfully. Negative scores, however, show that your skills needed for effective negotiating can use improvement!

ANSWER KEY

	(a)	(b)	(c)	(d)	(e)
1.	+20	+15	+ 5	- 10	- 20
2.	- 10	- 5	+10	+10	- 5
3.	- 15	+15	+10	- 15	+ 5
4.	+10	+ 5	- 10	+10	- 5
5.	+ 3	+ 6	+ 6	- 3	- 5
6.	+15	+10	0	- 10	- 15
7.	- 10	- 5	+ 5	+10	+10
8.	- 10	+ 5	+10	+13	+10
9.	+20	+15	+ 5	- 10	- 20
10.	+ 5	+15	+10	- 5	0
11.	- 15	- 10	0	+10	+15
12.	+16	+12	+ 4	- 5	- 15
13.	+12	+ 6	0	- 2	- 10
14.	+15	+10	+ 5	- 5	- 10
15.	- 10	- 5	+ 5	+15	+15
16.	+15	+10	- 3	- 10	- 15
17.	+ 5	+10	0	- 3	- 10
18.	+10	+ 8	+ 3	- 3	- 10
19.	+15	+10	+ 5	- 5	- 15
20.	+15	+10	+ 5	0	- 5
21.	- 8	- 3	+ 3	+ 8	+12
22.	+10	+ 8	+ 2	- 3	- 10
23.	+10	+ 8	+ 3	0	- 5
24.	+10	+10	+ 8	- 8	- 15
25.	+12	+ 8	+ 4	- 5	- 10
26.	+15	+10	0	- 10	- 15

IV. Evaluation

1. Describe the rationale for collaboration in early intervention. Use the case study involving Polly **[Handout #3]** to support why a collaborative model is key to delivering early intervention services.

2. Describe the four barriers to collaboration. For each barrier describe at least one strategy that could be used to overcome the barrier.

3. Describe the different types of conflict management skill, including the strengths and weakness of each approach.

V. Suggested Reference

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Instructional Module

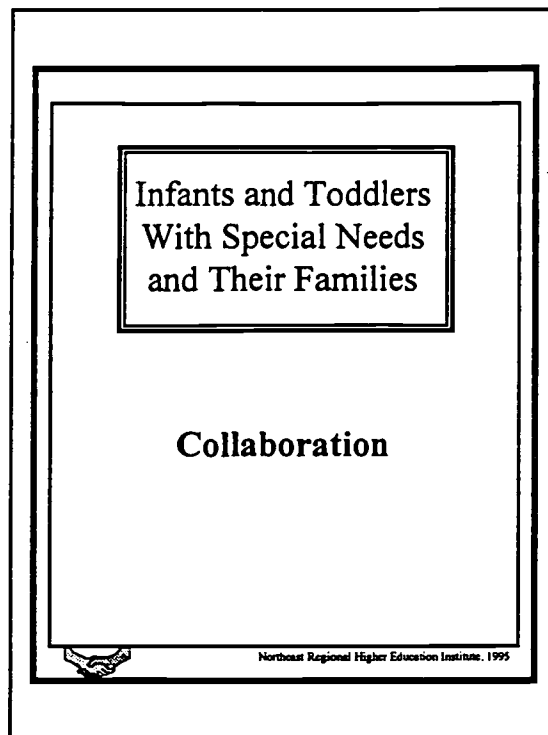## Infants and Toddlers with Disabilities and Their Families:

Collaboration

PART TWO

Supporting Materials

I.   Lecture Notes
II.   Student Handouts for Note-Taking
III. Additional Student Handouts
IV. Transparency Samples

Faculty Presentation Guide

Infants and Toddlers
With Special Needs
and Their Families

Collaboration

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Faculty Presentation Guide

Collaborations Transparency #1

Objectives

Participants will be able to:

- ✓ Provide a rationale for collaboration in early intervention
- ✓ Describe the barriers to collaboration
- ✓ Describe ways in which individuals manage conflict during collaboration
- ✓ Identify the types of conflict management style used by an individual
- ✓ Describe ways to resolve conflict

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide

Collaboration Transparency #2

Rationale

✓ Improvement of service delivery

✓ Reduction in service duplicatio

✓ Links amoung families and professionals for efficient service utilities

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide

Collaborations Transparency #3

Conflict Management Styles

✓ Competitive

✓ Avoidance

✓ Accommodating

✓ Compromising

✓ Collaborative

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide

Collaborations Transparency #4

Competitive Style: people who try to overpower the others with whom they have a conflict

- goal is "winning" regardless of negative repercussions
- others may stop interacting with you in a meaningful way
- can seriously damage/inhibit collaborative relationships

+ appropriate when ethical issues are at stake
+ when you are certain you are right

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Lecture Notes

Faculty Presentation Guide

Collaborations Transparency #5

Avoidance Style: people who prefer to avoid conflict by ignoring the discrepancy between their own goals and those of others

- gives the appearance that all is well, but it is not

- conflict that is not resolved can continue to plague the group

- conflict can escalate from inaction

+ when conflict is emotionally laden, temporary avoidance allows involved individuals to regain control of their emotions

+ when there is not adequate time to constructively address the conflict

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Collaborations Transparency #

Accommodating Style: people who put aside their own needs in order to ensure that others' needs are met

- may feel as though others are taking advantage of you

- you may have the right answer

- others may devalue your ideas if you accommodate too often

+ when conflict is relatively unimportant

+ brings conflict to a quick close

+ when you cannot alter the situation

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Lecture Notes

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Compromising Style: people who give up some on an issue while asking others to do the same

- doesn't meet the needs of all

- may feel dissatisfied if you are competitive by nature

+ is acceptable to all

+ useful when time is limited

+ when deadlocked in conflict over an issue

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Lecture Notes

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Collaborations Transparency #8

Collaborative Style: people who utilize a high degree of both assertiveness and cooperativesness

- time consuming

- requires professionals to learn about and trust one another

+ may develop new and creative alternatives to conflict

+ common commitment and clarity of issues results in less conflict and greater satisfaction

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Lecture Notes

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Collaborations Transparency #9

Barriers to Collaborations

✓ Competitiveness Between Agencies

✓ Lack of Organizational Structure for Coordination

✓ Technical Factors

✓ Personnel

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Collaborations Transparency #10

Competitiveness Between Agencies

✓ Turf issues

✓ Lack of information about other agencies' functions

✓ Political issues

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Lecture Notes

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Faculty Presentation Guide
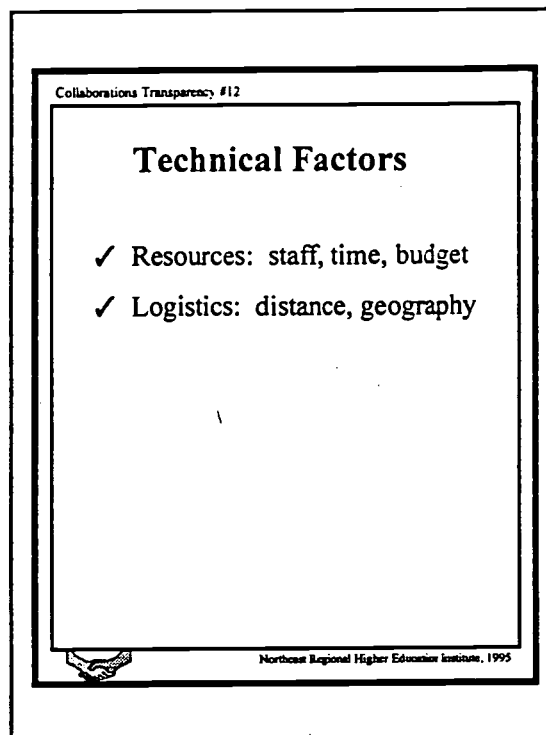
Lack of Organizational Structure for Coordination

✓ Differing philosophies

✓ Independent goals

✓ Haphazard team process

✓ Lack of facilitator

✓ Lack of monitoring and evaluation process

✓ Lack of planning

✓ Lack of power and authority to make and implement decisions

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Lecture Notes

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Collaborations Transparency #12

Technical Factors

✓ Resources: staff, time, budget

✓ Logistics: distance, geography

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Lecture Notes

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Collaborations Transparency #13

Personnel

✓ Parochial interests

✓ Resistance to change

✓ Staff attitudes

✓ Lack of commitment to community needs

✓ Questionable administrative support

✓ Discipline-specific jargon and perspectives

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide

Collaborations Transparency #14

Steps for Resolving Conflict

✓ Clarify issues objectively

✓ Set expectations and outcomes

✓ Communicate clearly

✓ Use a variety of strategies

✓ Problem solving

✓ Brainnstorming

✓ Selecting from options

✓ Negotiation

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide

Collaborations Transparency #15

Negotiation Strategies

✓ Separate the people from the problem

✓ Focus on mutual interests

✓ Invent options and alternatives for mutual gain

✓ Manage anger and resistance

✓ Insist on using objective criteria

✓ Select options and alternatives

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Lecture Notes

Infants and Toddlers
With Special Needs
and Their Families

Collaboration

Objectives

Participants will be able to:

✓ Provide a rationale for collaboration in early intervention

✓ Describe the barriers to collaboration

✓ Describe ways in which individuals manage conflict during collaboration

✓ Identify the types of conflict management style used by an individual

✓ Describe ways to resolve conflict

Rationale

✓ Improvement of service delivery

✓ Reduction in service duplicatio

✓ Links amoung families and professionals for efficient service utilities

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Collaborations Transparency #3

Conflict Management Styles

✓ Competitive

✓ Avoidance

✓ Accommodating

✓ Compromising

✓ Collaborative

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Collaborations Transparency #4

Competitive Style: people who try to overpower the others with whom they have a conflict

- goal is "winning" regardless of negative repercussions
- others may stop interacting with you in a meaningful way
- can seriously damage/inhibit collaborative relationships

+ appropriate when ethical issues are at stake
+ when you are certain you are right

Northwest Regional Higher Education Institute, 1993

Collaborations Transparency #5

Avoidance Style: people who prefer to avoid conflict by ignoring the discrepancy between their own goals and those of others

- gives the appearance that all is well, but it is not
- conflict that is not resolved can continue to plague the group
- conflict can escalate from inaction

+ when conflict is emotionally laden, temporary avoidance allows involved individuals to regain control of their emotions
+ when there is not adequate time to constructively address the conflict

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Collaborations Transparency #6

Accommodating Style: people who
put aside their own needs in order to
ensure that others' needs are met

- may feel as though others are taking advantage of you	+ when conflict is relatively unimportant
- you may have the right answer	+ brings conflict to a quick close
- others may devalue your ideas if you accommodate too often	+ when you cannot alter the situation

Northwest Regional Higher Education Institute, 1996

Collaborations Transparency #7

Compromising Style: people
who give up some on an issue
while asking others to do the same

- doesn't meet the needs of all	+ is acceptable to all
	+ useful when time is limited
- may feel dissatisfied if you are competitive by nature	+ when deadlocked in conflict over an issue

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Collaborations Transparency #8

Collaborative Style: people who
utilize a high degree of both
assertiveness and cooperativeness

- time consuming	+ may develop new and creative alternatives to conflict
- requires professionals to learn about and trust one another	
	+ common commitment and clarity of issues results in less conflict and greater

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Barriers to Collaborations

✓ Competitiveness Between Agencies

✓ Lack of Organizational Structure for Coordination

✓ Technical Factors

✓ Personnel

Competitiveness Between Agencies

✓ Turf issues

✓ Lack of information about other agencies' functions

✓ Political issues

Lack of Organizational Structure for Coordination

✓ Differing philosophies

✓ Independent goals

✓ Haphazard team process

✓ Lack of facilitator

✓ Lack of monitoring and evaluation process

✓ Lack of planning

✓ Lack of power and authority to make and implement decisions

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Technical Factors

✓ Resources: staff, time, budget
✓ Logistics: distance, geography

Personnel

✓ Parochial interests
✓ Resistance to change
✓ Staff attitudes
✓ Lack of commitment to community needs
✓ Questionable administrative support
✓ Discipline-specific jargon and perspectives

Steps for Resolving Conflict

✓ Clarify issues objectively
✓ Set expectations and outcomes
✓ Communicate clearly
✓ Use a variety of strategies
✓ Problem solving
✓ Brainnstorming
✓ Selecting from options
✓ Negotiation

Negotiation Strategies

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✓ Insist on using objective criteria

✓ Select options and alternatives

Handout # 1

THOMAS-KILMANN CONFLICT MODE INSTRUMENT*

Consider situations in which you find your wishes differing from those of another person. How do you usually respond to such situations? Following are several pairs of statements describing possible behavioral responses. For each pair, please circle the "A" or "B" statement that is most characteristic of your own behavior. In many cases, neither the "A" nor the "B" statement may be very typical of your behavior; but please select the response that you would be more likely to use.

1. A. There are times when I let others take responsibility for solving the problem.
   B. Rather than negotiate the things on which we disagree, I try to stress those things upon which we both agree.

2. A. I try to find a compromise solution.
   B. I attempt to deal with all of his/her and my concerns.

3. A. I am usually firm in pursuing my goals.
   B. I might try to soothe the other's feelings and preserve our relationship.

4. A. I try to find a compromise solution.
   B. I sometimes sacrifice my own wishes for the wishes of the other person.

5. A. I consistently seek the other's help in working out a solution.
   B. I try to do what is necessary to avoid useless tensions.

6. A. I try to avoid creating unpleasantness for myself.
   B. I try to win my position.

7. A. I try to postpone the issue until I have had some time to think it over.
   B. I give up some points in exchange for others.

8. A. I am usually firm in pursuing my goals.
   B. I attempt to get all concerns and issues immediately out in the open.

9. A. I feel that differences are not always worth worrying about.
   B. I make some effort to get my way.

10. A. I am firm in pursuing my goals.
    B. I try to find a compromise solution.

11. A. I attempt to get all concerns and issues immediately out in the open.
    B. I might try to soothe the other's feelings and preserve our relationship.

12. A. I sometimes avoid taking positions which would create controversy.
    B. I will let the other person have some of his/her positions if he/she lets me have some of mine.

13. A. I propose a middle ground.
    B. I press to get my points made.

14. A. I tell the other person my ideas to ask for his/hers.
    B. I try to show the other person the logic and benefits of my position.

15.   A.   I might try to soothe the other's feelings and preserve our relationship.
        B.   I try to do what is necessary to avoid tensions.

16   A.   I try not to hurt the other's feelings.
        B.   I try to convince the other person of the merits of my position.

17.   A.   I am usually firm in pursuing my goals.
        B.   I try to do what is necessary to avoid useless tensions.

18.   A.   If it makes other people happy, I might let them maintain their views.
        B.   I will let other people have some of their positions if they let me have some of mine.

19.   A.   I attempt to get all concerns and issues immediately out in the open.
        B.   I try to postpone the issue until I have had some time to think it over.

20.   A.   I attempt to immediately work through our differences.
        B.   I try to find a fair combination of gains and losses for both of us.

21.   A.   In approaching negotiations, I try to be considerate of the other person's wishes.
        B.   I always lean toward a direct discussion of the problem.

22.   A.   I try to find a position that is intermediate between his/hers and mine.
        B.   I assert my wishes.

23.   A.   I am very often concerned with satisfying all our wishes.
        B.   There are times when I let others take responsibility for solving the problem.

24.   A.   If the other's position seems very important to him/her, I would try to meet his/her wishes.
        B.   I try to get the other person to settle for a compromise.

25.   A.   I try to show the other person the logic and benefits of my position.
        B.   In approaching negotiations, I try to be considerate of the other person's wishes.

26.   A.   I propose a middle ground.
        B.   I am nearly always concerned with satisfying all our wishes.

27.   A.   I sometimes avoid taking positions that would create controversy.
        B.   If it makes other people happy, I might let them maintain their views.

28.   A.   I am usually firm in pursuing my goals.
        B.   I usually seek the other's help in working out a solution.

29.   A.   I propose a middle ground.
        B.   I feel that differences are not always worth worrying about.

30.   A.   I try not to hurt the other's feelings.
        B.   I always share the problem with the other person so that we can work it out.

Scoring the Thomas-Kilmann Conflict Mode Instrument

Circle the letters below which you circled on each item of the questionnaire.

	Competing (forcing)	Collaborating (problem solving)	Compromising (sharing)	Avoiding (withdrawal)	Accommodating
1.				A	B
2.		B	A		
3.	A				B
4.			A		B
5.		A		B	
6.	B			A	
7.			B	A	
8.	A	B			
9.	B			A	
10.	A		B		
11.		A			B
12.			B	A	
13.	B		A		
14.	B	A			
15.				B	A
16.	B				A
17.	A			B	
18.			B		A
19.		A		B	
20.		A	B		
21.		B			A
22.	B		A		
23.		A		B	
24.			B		A
25.	A				B
26.		B	A		
27.				A	B
28.	A	B			
29.			A	B	
30.		B			A

Total number of items circled in each column

Competing	Collaborating	Compromising	Avoiding	Accommodating

In which column did you receive the highest score?

Handout #2

HOW WELL DO YOU NEGOTIATE?

A Self-Evaluation

Please circle the most appropriate answer.

1. Do you generally go into negotiations well prepared?
    (a) Very frequently
    (b) Often
    (c) Sometimes
    (d) Not very often
    (e) Play it by ear

2. How uncomfortable do you feel when facing direct conflict?
    (a) Very uncomfortable
    (b) Quite uncomfortable
    (c) Don't like it but face it
    (d) Enjoy the challenge somewhat
    (e) Welcome the opportunity

3. How do you look at negotiation?
    (a) Highly competitive
    (b) Mostly competitive but a good part cooperative
    (c) Mostly cooperative but a good part competitive
    (d) Very cooperative
    (e) About half cooperative and competitive

4. What kind of deal do you go for?
    (a) A good deal for both parties
    (b) A better deal for you
    (c) A better deal for him
    (d) A very good deal for you and better than no deal for him
    (e) Every person for themselves

5. Do you like to negotiate with merchants (furniture, cars, major appliances)?
    (a) Love it
    (b) Like it
    (c) Neither like nor dislike it
    (d) Rather dislike it
    (e) Hate it

6. Are you a good listener?
    (a) Very good
    (b) Better than most
    (d) Below average
    (e) Poor listener

7. How do you feel about ambiguous situations - situations which have a good many pros and cons?
    (a) Very uncomfortable. Like things one way or another.
    (b) Fairly uncomfortable.
    (c) Don't like it but can live with it.
    (d) Undisturbed. Find it easy to live with.
    (e) Like it that way. Things are hardly ever one way or another.

8. How would you feel about negotiating a 10% raise with your boss if the average raise in the department is 5%?
   (a) Don't like it at all. Would avoid it.
   (b) Don't like it but would make a pass at it reluctantly.
   (c) Would do it with little apprehension.
   (d) Make a good case and not afraid to try it.
   (e) Enjoy the experience and look forward to it.

9. How good is your business judgment?
   (a) Experience show that it's very good
   (b) Good
   (c) As good as most other executives
   (d) Not too good
   (e) I hate to say it, but I guess I'm not quite with it when it comes to business matters

10. When you have the power, do you use it?
    (a) I use it to the extent I can
    (b) I use it moderately without any guilt feelings
    (c) I use it on behalf of fairness as I see fairness
    (d) I don't like to use it
    (e) I take it easy on the other fellow

11. How do you feel about getting personally involved with the other party?
    (a) I avoid it
    (b) I'm not quite comfortable
    (c) Not bad - not good
    (d) I'm attracted to getting close to him
    (e) I go out of my way to get close. I like it that way.

12. How sensitive are you to the personal issues facing the opponent in negotiation? (The nonbusiness issues like job security, workload, vacation, getting along with the boss, not rocking the boat.)
    (a) Very sensitive
    (b) Quite sensitive
    (c) Moderately
    (d) Not too sensitive
    (e) Hardly sensitive at all

13. How committed are you to the opponent's satisfaction?
    (a) Very committed. I try to see that he doesn't get hurt
    (b) Somewhat committed
    (c) Neutral but I hope he doesn't get hurt
    (d) I'm a bit concerned
    (e) It's everyone for themselves

14. Do you carefully study the limits of the other person's power?
    (a) Very much so
    (b) Quite a bit
    (c) I weigh it
    (d) It's hard to do because I'm not him
    (e) I let things develop at the session

15. How do you feel about making a very low offer when you buy?
    (a) Terrible
    (b) Not too good but I do it sometimes
    (c) I do it only occasionally
    (d) It's hard to do because I'm not him
    (e) I make it a regular practice and feel quite comfortable

16. How do you usually give in?
    (a) Very slowly, if at all
    (b) Moderately slowly
    (c) About at the same pace he does
    (d) I try to move it along a little faster by giving more
    (e) I don't mind giving in hefty chunks and getting to the point

17. How do you feel about taking risks that affect your career?
    (a) Take considerably larger risks than most people
    (b) Somewhat more risk than most
    (c) Somewhat less risk than most
    (d) Take slight risk on occasion but not much
    (e) Rarely take career risks

18. How do you feel with those of higher status?
    (a) Very comfortable
    (b) Quite comfortable
    (c) Mixed feelings
    (d) Somewhat uncomfortable
    (e) Very uncomfortable

19. How well did you prepare for the negotiation of the last house or car you bought?
    (a) Thoroughly
    (b) Quite well
    (c) Moderately
    (d) Not well
    (e) Played it by ear

20. How well do you think when **not** under pressure (compared to your peers)?
    (a) Very well
    (b) Better than most
    (c) Average
    (d) A little worse than most
    (e) Not too good

21. How would you feel if you had to say, "I don't understand that", four times after four explanations?
    (a) Terrible - wouldn't do it
    (b) Quite embarrassed
    (c) Would feel awkward
    (d) Would do it without feeling too badly
    (e) Wouldn't hesitate

22. How well do you handle tough questions in negotiations?
    (a) Very well
    (b) Above average
    (c) Average
    (d) Below average
    (e) Poorly

23. Do you ask probing questions:
    (a) Very good at it
    (b) Quite good
    (c) Average
    (d) Not very good
    (e) Pretty bad at it

24. Are you close-mouthed about your business?
    (a) Very secretive
    (b) Quite secretive
    (c) Secretive
    (d) Tend to say more than I should
    (e) Talk too much

25. How confident are you about your knowledge in your own field or profession (compared to your peers)?
    (a) Much more confident than most
    (b) Somewhat more confident
    (c) Average
    (d) Somewhat less confident
    (e) Not very confident, frankly

26. You are the buyer of some construction services. The design is changed because your spouse wants something different. The contractor now asks for more money for the change. You need him badly because he's well into the job. How do you feel about negotiating the added price?
    (a) Jump in with both feet
    (b) Ready to work it out but not anxious to
    (c) Don't like it but will do it
    (d) Dislike it very much
    (e) Hate the confrontation

INSTRUCTIONS

To evaluate yourself, check the answer key and add your positive and negative scores separately. Subtract them from each other.

A score between +250 and +340 indicates you are probably negotiating well already. The range of +180 to +250 suggests you have a good measure of the qualities it takes to negotiate successfully. Negative scores, however, show that your skills needed for effective negotiating can use improvement!

ANSWER KEY

1.	(a) + 20	(b) + 15	(c) + 5	(d) - 10	(e) - 20
2.	(a) - 10	(b) - 5	(c) + 10	(d) + 10	(e) - 5
3.	(a) - 15	(b) + 15	(c) + 10	(d) - 15	(e) + 5
4.	(a) + 10	(b) + 5	(c) - 10	(d) + 10	(e) - 5
5.	(a) + 3	(b) + 6	(c) + 6	(d) - 3	(e) - 5
6.	(a) + 15	(b) + 10	(c) 0	(d) - 10	(e) - 15
7.	(a) - 10	(b) - 5	(c) + 5	(d) + 10	(e) + 10
8.	(a) - 10	(b) + 5	(c) + 10	(d) + 13	(e) + 10
9.	(a) + 20	(b) + 15	(c) + 5	(d) - 10	(e) - 20
10.	(a) + 5	(b) + 15	(c) + 10	(d) - 5	(e) 0
11.	(a) - 15	(b) - 10	(c) 0	(d) + 10	(e) + 15
12.	(a) + 16	(b) + 12	(c) + 4	(d) - 5	(e) - 15
13.	(a) + 12	(b) + 6	(c) 0	(d) - 2	(e) - 10
14.	(a) + 15	(b) + 10	(c) + 5	(d) - 5	(e) - 10
15.	(a) - 10	(b) - 5	(c) + 5	(d) + 15	(e) + 15
16.	(a) + 15	(b) + 10	(c) - 3	(d) - 10	(e) - 15
17.	(a) + 5	(b) + 10	(c) 0	(d) - 3	(e) - 10
18.	(a) + 10	(b) + 8	(c) + 3	(d) - 3	(e) - 10
19.	(a) + 15	(b) + 10	(c) + 5	(d) - 5	(e) - 15
20.	(a) + 15	(b) + 10	(c) + 5	(d) 0	(e) - 5
21.	(a) - 8	(b) - 3	(c) + 3	(d) + 8	(e) + 12
22.	(a) + 10	(b) + 8	(c) + 2	(d) - 3	(e) - 10
23.	(a) + 10	(b) + 8	(c) + 3	(d) 0	(e) - 5
24.	(a) + 10	(b) + 10	(c) + 8	(d) - 8	(e) - 15
25.	(a) + 12	(b) + 8	(c) + 4	(d) - 5	(e) - 10
26.	(a) + 15	(b) + 10	(c) 0	(d) - 10	(e) - 15

Handout #3

Child: Polly (18 months)

Other Children: None

Parents: Brenda (28 years old)
                    Mark (29 years old)

Polly is 18 months old and lives with her family in central Connecticut. She was born prematurely, and is the sole survivor of a set of triplets. Polly was hospitalized for 13 months following birth. Her medical and developmental conditions include:

- Brain damage

- Heart problems

- Frequent infections that result in hospitalizations

- Dependency on oxygen

- Self-abusive episodes, including severe head banging

Because of her condition, Polly and her family have been receiving a variety of services, including:

- Health care through her primary pediatrician

- Occupational therapy once per week

- Speech therapy once every other week

- Physical therapy once per week

- Home education through a Regional Education Service Center (RESC) twice per week

- Sixteen hours a day of home nursing care

- Medical supply vendors delivering special formulas and oxygen

- Specialty care at the hospital through a variety of clinics

The family regularly has many professionals coming to and going from their house. During the five months that Polly has been home services have been provided by five therapists, two teachers, ten nurses, and a hospital-based team comprised of a physician, two nurses, a

psychologist, a full range of therapists, and a social worker. Also assigned to Polly's care are two social workers, three program supervisors, and three case managers from three separate agencies.

It is not surprising that Polly's parents are often caught in the middle of conflicts among the various professionals; each of whom seems to have a different opinion about Polly's needs, appropriate treatments, payment options, and service schedules. For example, each of the three case managers gave the family different information about their eligibility for various sources of public funding, including the Medicaid Waiver. As a result, their application for benefits was delayed and they had to pay several thousand dollars out-of-pocket for some of Polly's care. In addition, the nursing agency and the different therapists disagree about the amount of therapy Polly needs, and therefore do not cooperate with one another. Because there is no coordination among the service agencies and providers, the family finds that the services Polly receives often cause confusion in their lives. A week in their house looks like this:

- Monday: 16 hours nursing/teacher/ supervisor/Department of Income Maintenance case manager

- Tuesday: 16 hours nursing/OT/DMR case manager

- Wednesday: 16 hours nursing/teacher/ clinic visit at tertiary care hospital/PT

- Thursday: 16 hours nursing/PT/vendor delivery/nurse supervisor/ teacher

- Friday: 16 hours nursing/speech therapy/adaptive equipment fitting at tertiary care hospital

- Saturday: 16 hours nursing

- Sunday: 16 hours nursing

The family has concluded that caring for Polly is not the primary cause of their stress, rather that the multiple layers of fragmented services are causing much havoc in their family. Polly's parents are now seeking out-of-home placement for her because they feel the need to put some order back into their lives. Neither parent feels "functional" with so many people in and out of the house. In Polly's case, one of the intents of P.L. 99-457, reducing the likelihood of institutionalization, has not been realized.

Infants and Toddlers With Special Needs and Their Families

Collaborative Consultation

Objectives

Participants will be able to:

✓ Provide a rationale for consultation in early intervention

✓ Define collaborative consultation

✓ Describe principles of collaborative consultation

✓ Describe strategies to use during collaborative consultation

✓ Provide examples of collaborative consultation

Rationale

Consultation can:

✓ be used to resolve needs, issues, or problems

✓ improve the understanding that individuals have of issues and their ability to respond effectively to similar problems in the future

✓ decrease the number of service providers involved with direct service delivery

Definition

Collaboration Consultation is:

An interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems.

Principles of
Collaborative Consultation

✓ Mutual ownership of the process

✓ Recognition of individual differences in the change process

✓ Use of reinforcement principles and practices to improve skills, knowledge, and attitudes

✓ Use of data based decision making

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Strategies

✓ Treat others with respect

✓ Share relevant information

✓ Use appropriate language

✓ Listen to others

✓ Model the use of interview skills

✓ Demonstrate a willingness to learn

✓ Give and receive feedback

✓ Give others credit for their ideas and accomplishments

✓ Manage conflict and confrontation appropriately

✓ Adapt situational leadership to collaborative consultation

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Infants and Toddlers With Special Needs and Their Families

Collaboration

Objectives

Participants will be able to:

✓ Provide a rationale for collaboration in early intervention

✓ Describe the barriers to collaboration

✓ Describe ways in which individuals manage conflict during collaboration

✓ Identify the types of conflict management style used by an individual

✓ Describe ways to resolve conflict

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Rationale

✓ Improvement of service delivery

✓ Reduction in service duplicatio

✓ Links amoung families and professionals for efficient service utilities

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Conflict Management Styles

✓ Competitive

✓ Avoidance

✓ Accommodating

✓ Compromising

✓ Collaborative

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Competitive Style: people who try to overpower the others with whom they have a conflict

- goal is "winning" regardless of negative repercussions

- others may stop interacting with you in a meaningful way

- can seriously damage/inhibit collaborative relationships

+ appropriate when ethical issues are at stake

+ when you are certain you are right

Avoidance Style: people who prefer to avoid conflict by ignoring the discrepancy between their own goals and those of others

- gives the appearance that all is well, but it is not

- conflict that is not resolved can continue to plague the group

- conflict can escalate from inaction

+ when conflict is emotionally laden, temporary avoidance allows involved individuals to regain control of their emotions

+ when there is not adequate time to constructively address the conflict

Accommodating Style: people who put aside their own needs in order to ensure that others' needs are met

- may feel as though others are taking advantage of you

- you may have the right answer

- others may devalue your ideas if you accommodate too often

+ when conflict is relatively unimportant

+ brings conflict to a quick close

+ when you cannot alter the situation

Compromising Style: people who give up some on an issue while asking others to do the same

- doesn't meet the needs of all

- may feel dissatisfied if you are competitive by nature

+ is acceptable to all

+ useful when time is limited

+ when deadlocked in conflict over an issue

Collaborative Style: people who utilize a high degree of both assertiveness and cooperativesness

- time consuming

- requires professionals to learn about and trust one another

+ may develop new and creative alternatives to conflict

+ common commitment and clarity of issues results in less conflict and greater satisfaction

Barriers to Collaborations

✓ Competitiveness Between Agencies

✓ Lack of Organizational Structure for Coordination

✓ Technical Factors

✓ Personnel

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Competitiveness Between Agencies

✓ Turf issues

✓ Lack of information about other agencies' functions

✓ Political issues

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Lack of Organizational Structure for Coordination

✓ Differing philosophies

✓ Independent goals

✓ Haphazard team process

✓ Lack of facilitator

✓ Lack of monitoring and evaluation process

✓ Lack of planning

✓ Lack of power and authority to make and implement decisions

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Technical Factors

✓ Resources: staff, time, budget

✓ Logistics: distance, geography

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Personnel

✓ Parochial interests

✓ Resistance to change

✓ Staff attitudes

✓ Lack of commitment to community needs

✓ Questionable administrative support

✓ Discipline-specific jargon and perspectives

Northeast Regional Higher Education Institute, 1995

Steps for Resolving Conflict

✓ Clarify issues objectively

✓ Set expectations and outcomes

✓ Communicate clearly

✓ Use a variety of strategies

✓ Problem solving

✓ Brainnstorming

✓ Selecting from options

✓ Negotiation

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Negotiation Strategies

✓ Separate the people from the problem

✓ Focus on mutual interests

✓ Invent options and alternatives for mutual gain

✓ Manage anger and resistance

✓ Insist on using objective criteria

✓ Select options and alternatives

Infants and Toddlers With Special Needs and Their Families

Collaborative Consultation

Northeast Regional Higher Education Institute, 1995

Instructional Module

Infants and Toddlers with Disabilities and Their Families: Collaborative Consultation

I. **Objectives**

Participants will:

1. Provide a rationale for consultation in early intervention

2. Define collaborative consultation

3. Describe principles of collaborative consultation

4. Describe strategies to use during collaborative consultation

5. Provide examples of collaborative consultation

II.   OUTLINE

A.   Rationale--Consultation can:

    1.   be used to resolve a needs, issue or problem.

    2.   improve the understanding that individuals have of issues and their ability to respond effectively to similar problems on the future.

    3.   decrease the number of service providers involved with the direct service delivery.

B.   Definition: An interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems.

C.   Principles

    1.   Mutual ownership of the process

    2.   Recognition of individual differences in the change process

    3.   Use of reinforcement principles and practices to improve skills, knowledge and attitudes

    4.   Use of data based decision making

D.   Strategies

    1.   Treat others with respect

    2.   Share relevant information

    3.   Use appropriate language

    4.   Listen to others

    5.   Model the use of interview skills

    6.   Demonstrate a willingness to learn from others

    7.   Give and receive feedback

8. Give others credit for their ideas and accomplishments

9. Manage conflict and confrontation appropriately

10. Adapt situational leadership to Collaborative Consultation

E. Examples

1. Therapy

2. Childcare

F. Activity

1. Evaluate system

2. Evaluate work environment

III. Explanatory Material/Expansion of Module Outline

A. Rationale: Consultation Can: [Transparency 1]

A number of models for consultation have been used to provide services to children with disabilities (File & Kontos 1992). Generally speaking, consultation is the giving and taking of the information between two or more people to (1) resolve a need, issue, or problem; and (2) improve the understanding that one or both individuals have of these issues and their ability to respond effectively to similar problems in the future (Gutkin & Curtis 1982). One person may be involved with different consultations with different staff. What is most important, however, is the relationship between the two key individuals involved in the consultation. When the consultation involves providing services to a young child with a disability, the child becomes the third person involved.

Consultation can be used to provide two types of services to a child with a disability: direct and indirect (Idol 1993). The consultant can provide direct educational and related services, such as assessment of and instruction in a child's deficit area (Idol, Paolucci-Whitcomb, & Nevin 1986). The consultant can also provide assistance to teachers who have children with disabilities in their classrooms as well as to the parents of these children (Idol 1993). Within an early childhood program that includes children with disabilities, it seems clear that both consultant functions are necessary.

As stated, most of the empirical basis for using consultation has evolved from research on a school-age population of children with disabilities. Although this scope is limited, the studies confirm that consultation is an effective strategy for service delivery (Medway 1982; Medway & Updyke 1985; Sibley 1986; Gresham & Kendall 1987, West & Idol 1987; Kratochwill, Sheridan, & VanSomeren 1988; Bergan & Kratochwill 1990). In particular, consulting models of indirect service delivery in special education and related services has proven to be as effective as direct services provided in a pull-out (of the classroom) model when measures of children's achievement are compared (Miller & Sabatino 1978; Dunn 1990; Schulte, Osborne, & McKinney 1990). More important, however, teachers who called on consultants demonstrated positive changes in instructional techniques when using a consultant to meet a child's educational need (Meyers, Gelzheiser, & Yelich 1991). These

outcomes have been replicated within early childhood settings (Peck, Killen, & Baugmart 1989; Dunn 1990; Hanline 1990).

B. Definition: [Transparency 2]

Related research on consultation strategies has focused on the methods used during the process of problem solving (Tindal, Shinn, & Rodden-Nord 1990). Evidence suggests that both special educators and general educators prefer a collaborative model (Wenger 1979; Babcock & Pryzwansky 1983; Pryzwansky & White 1983) rather than an expert model. The collaborative model, derived from Tharp and Werzel 1969, has been defined as

> an interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems. The major outcome of collaborative consultation is to provide comprehensive and effective programs for students with special needs within the most appropriate context, thereby enabling them to achieve maximum constructive interaction with their nonhandicapped peers. (Idol, Paolucci-Whitcomb, & Nevin 1986, p. 1)

Collaborative consultation encompasses a number of interpersonal competencies that cross discipline boundaries, including written and oral communication skills; personal characteristics, such as the ability to be caring, respectful, empathic, congruent and open; and collaborative problem solving skills (West & Cannon 1988). The last attribute, in particular, is crucial to the development of a relationship of parity between both (or all, if there are more than two) individuals involved in the consultation.

C. Principles: [Transparency 3]

A number of principles have been identified as contributing to the successful implementation of collaborative consultation among professionals from disciplines (Idol, Paolucci-Whitcomb, & Nevin 1986):

• *Mutual ownership of the process.* It is important that the participants in the consultation together identifying the need, issue, or problem. They should accept mutual responsibility or ownership of the consulting process and subsequent outcomes. Each person must respect, recognize, and appreciate the others' expertise.

- *Recognition of individual differences in the change process.* All parties should be aware of the change process and the developmental stages of concern for change that have been identified (Hall & Loucks 1978). It is important that both recognize that people embrace change differently, at different rates and at different emotional levels.

- *Use of reinforcement principles and practices to improve skills, knowledge, and attitudes.* When all of those involved in the consultation use effective teaching skills with each other and with the child with disabilities, positive outcomes accrue for all.

- *Use of data-based decision making.* The implementation of collaborative consultation strategies requires the adoption of a model of evaluation that measures the functional outcome of a child's behavior. The effects of each participant on the identified need, issue, or problem must be analyzed continuously to evaluate the effectiveness of the collaboration.

D. Strategies: [Transparency 4]

A number of strategies have been identified to assist in the collaborative consultation process. These strategies are crucial to the delivery of services. They will be described:

1. *Treat others with respect.* Collaborators need to treat each other with respect (Corey & Corey, 1992; West et al., 1989) This is important throughout the consultation process, but it is especially important in gaining entry and building team goals. Collaborators can model respect for other people by listening to them, by sharing information, by engaging in joint problem solving, by maintaining confidentiality, and by treating one another in a mannerly fashion. Collaborators must listen to descriptions about what kind of special assistance other team members think they want and need. Likewise, collaborators need to explain what they think their own special skills are so that, together, they can determine how they can best work together to provide educational services. It is especially important that collaborators show respect for each other by keeping team information confidential (Brill, 1990; Lippitt & Lippitt, 1986; Shulman, 1984). Collaborators should never discuss other members of the team unless they have specific permission to do so.

2. *Share relevant information.* Collaborators need to share information about their own skills in assessment, instruction, and evaluation so

they will be able to determine when and how to request one another's assistance (Friend & Cook, 1992; West et al., 1989). Brief, clear descriptions of assessment, instruction, and evaluation instruments and techniques will enable collaborators to gain some idea about how they might use each other's assistance (Idol, 1993; Lippitt & Lippitt, 1986; Montgomery, 1980; West et al., 1989).

3. *Use appropriate language.* Appropriate language increases the probability of shared meaning (Friend & Cook, 1992, Idol, 1993; Johnson, 1986; Verderber, 1981). Collaborators should be able to describe their program goals and special skills in a language that is familiar to other school personnel. Occasionally, it is appropriate for collaborators to use a new term because it is the most effective and accurate way of describing a behavior, procedure, or material. When that happens, it is important for the sender to explain the new term and the purpose for its use so that it can quickly become shared information and therefore a part of all of the team members' repertoire.

4. *Listen to others.* Collaborators can use appropriate listening skills in at least two ways: First, they can model passive listening by just keeping quiet and really listening to what others say. Second, they can use active listening by providing feedback on what they think others have said. This feed back process provides others with the opportunity either to confirm that they heard correctly or to correct any inaccuracy the interpretation of their original message (Conoley & Conoley, 1982; Gordon, 1980; Johnson, 1986, 1990; Montgomery 1980, Verderber, 1981. West et al. (1989, Module 14) have offered training opportunities on six specific appropriate listening and responding skills (acknowledging, paraphrasing, reflecting, clarifying, elaborating, and summarizing).

5. *Model the use of interview skills.* Collaborators need to use specific interviewing skills so that they can gain information from others, share information, express and explore their feelings about working together, solve problems, and plan appropriate future action on behalf of learners. The interview process provides an opportunity for collaborators to model purposeful and directed verbal interactions that can help to increase a shared information base and a willingness to work with others. Later, classroom teachers can use those same skills when working with learners in their own classrooms (Benjamin, 1987; Molyneaux & Lane, 1982; West et al., 1989).

6. *Demonstrate a willingness to learn from others.* Collaborators must demonstrate a willingness to learn from others if they want others to learn from them (Montgomery, 1980). Collaborative consultation is a problem-solving process in which the members have many chances to learn and teach one another. All members have specific, yet different, skills and knowledge to share. Some collaborators have knowledge about special education assessment and intervention techniques, while others have specific knowledge about curriculum, child development, content area specifics, and so on. Thus, collaborative consultation team members have different but equally valued knowledge and skills that need to be s hared for the benefit of all learners (Gordon, 1980; Lippitt & Lippitt, 1986).

7. *Give and receive feedback.* Giving and receiving feedback is of vital importance to the chance process (Conoley & Conoley, 1982; Friend & Cook, 1992; Heresy & Blanchard, 1988; Idol, 1993; Johnson, 1986; Verderber, 1981; West et al., 1989, Module 21): It is often helpful to identify at least two areas that deserve positive feedback; one area that needs improvement, and then one or two areas of strength. Feedback should be specific, immediate, and appropriate. Collaborators should engage in both giving and receiving feedback. One strategy for doing this is to say, "I think I did those two things very well, but it seems as if I need to improve here. However, it does make me feel good to know that identifying and adapting intervention techniques are two of my major strengths. How do you think I could improve those two techniques?" This situation provides an opportunity for collaborators to model both the process of self-evaluation and the process of requesting feedback. Collaborators also model the technique of requesting a perception check by obtaining their team members' view of their own skills. Collaborators can give feedback by responding to others' views of their own strengths and areas in need of improvement. A major concept that is built through this process is that the focus of change is on behaviors, not people. There are no good or bad people or techniques but rather areas of strength or effectiveness and areas that need improvement. Patience, mutual respect, and shared skills can, however, make the process of giving and receiving feedback easier and more enjoyable.

8. *Give others credit for their ideas and accomplishments.* Collaborative consultation is a shared process of responsibilities and rewards (West et al., 1989, Module 22). Collaborators can model the practice of

giving others credit for their ideas and accomplishments. That includes providing credit for ideas in written materials, as well. This practice increases the probability that collaborators will share their knowledge and rewards, thus providing increased strength and willingness to identify and solve more problems.

9. *Manage conflict and confrontation appropriately.* Conflicts or disagreements are inevitable in human relationships. The goal is for collaborators to model the appropriate use of confrontation skills so that a no-lose method of resolving conflict is utilized. When appropriate confrontation skills are used, both parties express their points of view and listen to each other. They use "I" messages to express their needs, feelings, and concerns, instead of blaming the other person for their conflicts. Finally, they search together for creative and mutually acceptable solutions (Friend & Cook, 1992, Gordon, 1980; Johnson, 1986, 1990, West et al., 1989, Module 23).

10. *Adapt situational leadership to Collaborative consultation.* Collaborators need to determine the attitude and skill levels of the people they will be collaborating with, so that they can adjust their collaboration styles to match the maturity level of each member of the group. Maturity levels should be identified by determining each member's willingness, as well as skills, and knowledge to provide special or remedial services. The amount of special education coursework the collaborator has completed and the number of years the collaborator provided effective services are two possible indicators of their willingness and ability to work with learners with special needs. The concept of situational collaboration has been adapted from situational leadership, which was described by Hersey and Blanchard (1988) and Toseland and Rivas (1984).

Consultation appears likely to become an increasingly prominent method of service delivery for early childhood special educators and related- service personnel (File & Kontos 1992). Many program models that include children with disabilities in community early childhood programs have supported this model (Bagnato, 1988; Bruder 1993). However, the strategy of collaborative consultation for service delivery by professionals from different disciplines cannot be advocated without noting the barriers. Staff from different agencies who often have different philosophies of service, financial resources, and time constraints, may not understand and respect one another's professional frameworks and skills

(Johnson, Pugach, & Hammitte 1988; Johnson Pugach 1991). Sometimes staff from one agency or discipline perceive themselves to be more highly skilled than are staff from the other discipline (Carter 1989; Pugach & Johnson 1989). This often can happen in the context of a collaboration between an early childhood teacher and a special educator; the teacher may be less skilled than the special educator in intervention, although she is more skilled in many other aspects of working with young children. All staff involved need to acknowledge such existing barriers before beginning the collaboration. All staff involved must demonstrate mutual respect for each other because each professional will benefit from the others' expertise. This is the very core of a collaborative consultation relationship.

E.   Example:

How could the collaborative consultation model be used in the following case historues:

1. Therapy: [Handout 1]

Child: Kara (age 4 years)

Other Children: None

Parent(s)   Maya (mother age 24)

            John (father age 23)

Possible solution for implementing the collaborative consultation model of service delivery:

Before asking for Kara's removal from the Head Start program, the program director requested a meeting between the classroom teacher, the speech pathologist, the psychologist, and Kara's parents. At the meeting the group decided to try one more strategy to try to help Kara's behavior. The speech pathologist agreed to redistribute her time with Kara, although she expressed uncertainty about the chances of Kara learning better communication and language skills outside a distraction-free therapy environment. She began to spend time with Kara in the classroom twice a week and used her third day to meet with the teacher during lunchtime to help identify approaches the teacher could use to help Kara communicate

her needs more effectively. The psychologist also agreed to come to the classroom twice a week to record the times when Kara's problematic behavior seemed be worse. He met with the teacher and parents weekly to identify the events that led to the behavior episodes and the strategies that seemed to help Kara. He also demonstrated to both Kara's teacher and her parents techniques that seemed to be effective with Kara. For example, Kara was given a sticker chart, which was used by the teacher every time Kara appropriately communicated her needs. She was also given more verbal cues to prepare her for transitions, a particularly difficult time for her. After six weeks of consultation, Kara's behavior showed a big improvement, and the psychologist reduced his time investment to twice-a-month visits with the teacher. Kara's speech and language has improved, and the speech pathologist has learned to provide services within Kara's classroom activities, in group situations. The teacher also feels much more comfortable and effective in meeting Kara's needs.

2. Childcare: [Handout 2]

Child: Joley (age 4 years)

Other Children: None

Parent(s)   Mary (mother)

Possible solution for implementing the collaborative consultation model of service delivery:

Joley's mother agreed with the child care staff to request a meeting with the staff at the special education center. At the meeting she asked if there was any way the special education staff could help the child care staff. The members of the special education staff agreed to consult with the child care staff on a weekly basis to help them teach intervention techniques to use with Joley to address all of her developmental needs. The process was hard in the beginning because schedules were difficult to coordinate. Before long, however, members from both programs felt comfortable with each other and began to jointly help each other problem solve to meet Joley's needs. After four months of this regular communication and teaching

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and learning from each other, the special education staff believed that they should stop taking Joley out of her natural environment every day because the child care staff was doing such a good job incorporating her individualized interventions and adaptations into their classroom routines. Certain members of the special education team increased their visits to see Joley at the child care center to make up for their lack of daily contact, and evaluations of her progress suggested that this change in intervention benefited her enormously.

F.   Activities:

Use the following evaluation tools to perform self checks

1.   Evaluate the system [Handout 3]

Evaluation of system for monitoring collaborator acquisition and practice of generic principles of collaborative consultation.

	Never		So-So		Often
I feel team ownership of the identified problem.	1	2	3	4	5
I recognize and respect individual differences.	1	2	3	4	5
I use situational leadership.	1	2	3	4	5
I use cooperative conflict-resolution processes.	1	2	3	4	5
I use appropriate interviewing skills.	1	2	3	4	5
I actively listen to others.	1	2	3	4	5
I communicate using common nonjargon and positive nonverbal language.	1	2	3	4	5

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2. Evaluate the work environment [Handout 4]

Collaborative work environment self-assessment.

Instructions: The norms for staff behavior listed below are those frequently found in collaborative work environments in schools. Please read each statement carefully. Then rate the degree to which each statement reflects the current work environment in your school, with 1 = our staff always behaves this way; 2 = our staff behaves this way most of the time; 3 = our staff behaves this way sometimes; 4 = our staff behaves this way rarely; or 5 = our staff never behaves this way.

_____ 1. The staff shares a common language about instructional techniques.

_____ 2. The staff often observes each other in their classrooms and give feedback on instruction.

_____ 3. The staff frequently discusses instructional techniques and methods in the workroom/lounge.

_____ 4. The staff works together to master new instructional methods or strategies.

_____ 5. The staff plans and designs educational materials together.

_____ 6. The staff pools their expertise and shares their resources with each other.

_____ 7. The staff learns from and with each other.

_____ 8. Time is specifically devoted at staff meetings to demonstrate and discuss innovative educational techniques, materials, or strategies.

_____ 9. Discussion in the staff lounge/workroom centers mostly on instructional practices rather than on social concerns or complaints about learners.

_____ 10. Time is specifically provided for professional staff to plan and problem-solve together.

IV. Evaluation

The case histories may be used, also, as evaluation tools by asking one or more of the following questions:

1. How could the collaborative consultation model be used to improve services for this child.

2. Why should the collaborative consultation model be used in early intervention? Use facts from the case history to support your rationale.

Handout #1

Child: Kara (age 4 years)

Other Children: None

Parent(s)   Maya (mother age 24)

                 John (father age 23)

Kara attends a Head Start Program five mornings a week. In October Kara was referred to the special needs coordinator of the local Head Start program because of her behavior problems. Her parents agreed to have her tested by the local school district special education team. The special education team determined that Kara was not eligible for their preschool services but that she could receive speech and language services because of articulation problems. The speech pathologist from the school district began to see Kara three mornings a week in a small room set aside for speech therapy at the Head Start program. The Head Start teacher did not know what went on in the speech room but hoped it was helping Kara's speech. Unfortunately, though, Kara's behavior in class kept getting worse, so that the Head Start director asked the local mental health center to send a psychologist to the classroom to observe Kara. The psychologist asked the classroom teacher to provide a lot of data and suggested that she change her style of teaching. The teacher tried at first, but Kara's behavior did not improve, and the whole classroom routine was disrupted. The psychologist said that he could come to the classroom two hours a week to implement a behavior modification program, but he did not know if it would help. The Head Start staff (especially the teacher) now feel that Kara should be removed from Head Start and sent to a special education school because neither of the specialists have been able to help her. If the special education school will not take her, she will just have to stay at home.

Handout #2

Child: Joley (age 4 years)

Other Children: None

Parent(s)   Mary (mother)

Joley is 4 years old and has Down Syndrome. She has two younger brothers. Her mom, Mary, is single and works two jobs. Joley attends the Busy Bee Child Care Center for a total of seven hours a day. Her mom drops her off at 7:30 for breakfast. Joley spends the rest of the morning at the child care center. She is picked up by a bus at 11:30 to go to a preschool special education center (40 minutes away), where she attends a class every afternoon and receives special education and related services that include speech, occupational, and physical therapy. She returns to the child care center every day at 3:00 p.m. and stays until 6:00 p.m., when her grandmother picks her up. Joley does very well at the child care program, but the teachers think they should be doing more with her. They wish they knew what happened during the special education class and what all the special staff did to her. They also worry about all the transitions Joley has to make in one day. Joley's mother has also expressed concern about all the traveling her daughter has to do between the two programs.

Evaluation of system for monitoring collaborator acquisition and practice of generic principles of collaborative consultation.

Collaborator: _____ **Date:** _____

	Never		**So-So**		**Often**
I feel team ownership of the identified problem.	1	2	3	4	5
I recognize and respect individual differences.	1	2	3	4	5
I use situational leadership.	1	2	3	4	5
I use cooperative conflict-resolution processes.	1	2	3	4	5
I use appropriate interviewing skills.	1	2	3	4	5
I actively listen to others.	1	2	3	4	5
I communicate using common nonjargon and positive nonverbal language.	1	2	3	4	5

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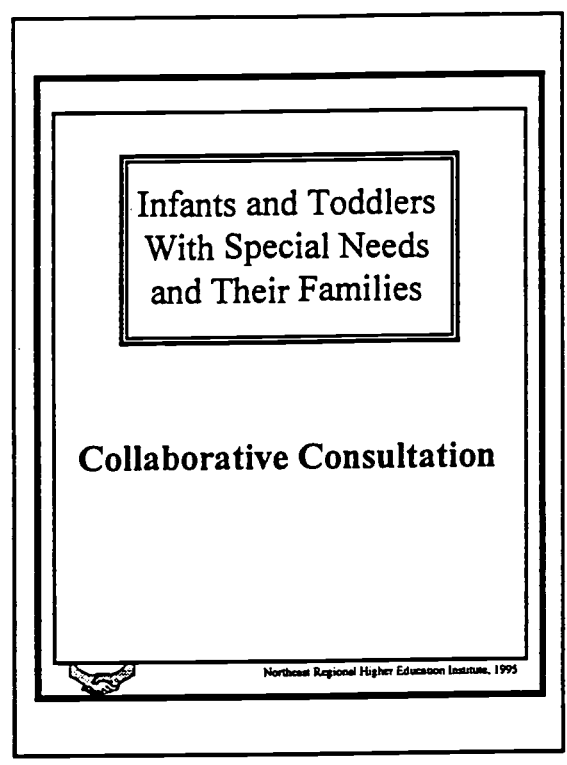## Infants and Toddlers with Disabilities and Their Families:

Collaborative Consultation

PART TWO

Supporting Materials

I.   Lecture Notes
II. Student Handouts for Note-Taking
III. Additional Student Handouts
IV. Transparency Samples

Faculty Presentation Guide

Infants and Toddlers
With Special Needs
and Their Families

Collaborative Consultation

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Faculty Presentation Guide

Collaborative Consultation Transparency #1

Objectives

Participants will be able to:

✓ Provide a rationale for consultation in early intervention

✓ Define collaborative consultation

✓ Describe principles of collaborative consultation

✓ Describe strategies to use during collaborative consultation

✓ Provide examples of collaborative consultation

Northeast Regional Higher Education Institute, 1995

Lecture Notes

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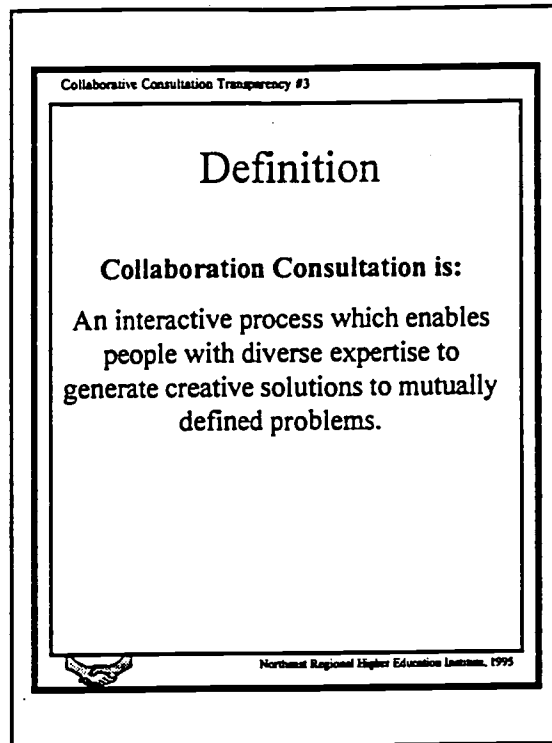Collaborative Consultation Transparency #2

Rationale

Consultation can:

✓ be used to resolve needs, issues, or problems

✓ improve the understanding that individuals have of issues and their ability to respond effectively to similar problems in the future

✓ decrease the number of service providers involved with direct service delivery

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Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide

Collaborative Consultation Transparency #3

Definition

Collaboration Consultation is:

An interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems.

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Lecture Notes

**Faculty
Presentation
Guide**

Collaborative Consultation Transparency #4

Principles of
Collaborative Consultation

✓ Mutual ownership of the process

✓ Recognition of individual differences
in the change process

✓ Use of reinforcement principles and
practices to improve skills,
knowledge, and attitudes

✓ Use of data based decision making

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Lecture Notes

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Faculty Presentation Guide

Collaborative Consultation Transparency #5

Strategies

✓ Treat others with respect

✓ Share relevant information

✓ Use appropriate language

✓ Listen to others

✓ Model the use of interview skills

✓ Demonstrate a willingness to learn

✓ Give and receive feedback

✓ Give others credit for their ideas and accomplishments

✓ Manage conflict and confrontation appropriately

✓ Adapt situational leadership to collaborative consultation

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Lecture Notes

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Infants and Toddlers
With Special Needs
and Their Families

Collaborative Consultation

Objectives

Participants will be able to:

✓ Provide a rationale for consultation in
   early intervention

✓ Define collaborative consultation

✓ Describe principles of collaborative
   consultation

✓ Describe strategies to use during
   collaborative consultation

✓ Provide examples of collaborative
   consultation

Rationale

Consultation can:

✓ be used to resolve needs, issues, or
   problems

✓ improve the understanding that
   individuals have of issues and their
   ability to respond effectively to
   similar problems in the future

✓ decrease the number of service
   providers involved with direct service
   delivery

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   appropriately

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   collaborative consultation

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Handout #1

> **Child:** Kara (age 4 years)
>
> **Other Children:** None
>
> **Parent(s)** Maya (mother age 24)
>
> John (father age 23)

Kara attends a Head Start Program five mornings a week. In October Kara was referred to the special needs coordinator of the local Head Start program because of her behavior problems. Her parents agreed to have her tested by the local school district special education team. The special education team determined that Kara was not eligible for their preschool services but that she could receive speech and language services because of articulation problems. The speech pathologist from the school district began to see Kara three mornings a week in a small room set aside for speech therapy at the Head Start program. The Head Start teacher did not know what went on in the speech room but hoped it was helping Kara's speech. Unfortunately, though, Kara's behavior in class kept getting worse, so that the Head Start director asked the local mental health center to send a psychologist to the classroom to observe Kara. The psychologist asked the classroom teacher to provide a lot of data and suggested that she change her style of teaching. The teacher tried at first, but Kara's behavior did not improve, and the whole classroom routine was disrupted. The psychologist said that he could come to the classroom two hours a week to implement a behavior modification program, but he did not know if it would help. The Head Start staff (especially the teacher) now feel that Kara should be removed from Head Start and sent to a special education school because neither of the specialists have been able to help her. If the special education school will not take her, she will just have to stay at home.

Handout #2

Child: Joley (age 4 years)

Other Children: None

Parent(s) Mary (mother)

Joley is 4 years old and has Down Syndrome. She has two younger brothers. Her mom, Mary, is single and works two jobs. Joley attends the Busy Bee Child Care Center for a total of seven hours a day. Her mom drops her off at 7:30 for breakfast. Joley spends the rest of the morning at the child care center. She is picked up by a bus at 11:30 to go to a preschool special education center (40 minutes away), where she attends a class every afternoon and receives special education and related services that include speech, occupational, and physical therapy. She returns to the child care center every day at 3:00 p.m. and stays until 6:00 p.m., when her grandmother picks her up. Joley does very well at the child care program, but the teachers think they should be doing more with her. They wish they knew what happened during the special education class and what all the special staff did to her. They also worry about all the transitions Joley has to make in one day. Joley's mother has also expressed concern about all the traveling her daughter has to do between the two programs.

Handout #3

Evaluation of system for monitoring collaborator acquisition and practice of generic principles of collaborative consultation.

Collaborator: _____ **Date:** _____

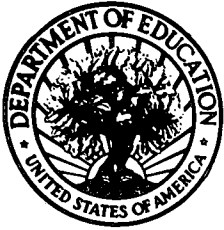|	Never		So-So		Often
	1	2	3	4	5
I feel team ownership of the identified problem.	1	2	3	4	5
I recognize and respect individual differences.	1	2	3	4	5
I use situational leadership.	1	2	3	4	5
I use cooperative conflict-resolution processes.	1	2	3	4	5
I use appropriate interviewing skills.	1	2	3	4	5
I actively listen to others.	1	2	3	4	5
I communicate using common nonjargon and positive nonverbal language.	1	2	3	4	5

Handout #4

Collaborative work environment self-assessment.

Name:_____ Postion:_____ School/Unit_____

Instructions: The norms for staff behavior listed below are those frequently found in collaborative work environments in schools. Please read each statement carefully. Then rate the degree to which each statement reflects the current work environment in your school, with 1 = our staff always behaves this way; 2 = our staff behaves this way most of the time; 3 = our staff behaves this way sometimes; 4 = our staff behaves this way rarely; or 5 = our staff never behaves this way.

____ 1. The staff shares a common language about instructional techniques.

____ 2. The staff often observes each other in their classrooms and give feedback on instruction.

____ 3. The staff frequently discusses instructional techniques and methods in the workroom/lounge.

____ 4. The staff works together to master new instructional methods or strategies.

____ 5. The staff plans and designs educational materials together.

____ 6. The staff pools their expertise and shares their resources with each other.

____ 7. The staff learns from and with each other.

____ 8. Time is specifically devoted at staff meetings to demonstrate and discuss innovative educational techniques, materials, or strategies.

____ 9. Discussion in the staff lounge/workroom centers mostly on instructional practices rather than on social concerns or complaints about learners.

____ 10. Time is specifically provided for professional staff to plan and problem-solve together.

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