



First Steps

TRAINING TIMES

Volume 1 Issue 1

December 2004

Welcome to the first issue of the *TRAINING TIMES*.

UTS-Programmatic Training at ProKids has developed this quarterly training newsletter to provide enrolled First Steps providers timely updates regarding First Steps policies and procedures, in conjunction with valuable articles and information to enhance your professional development as an early intervention provider. The *Training Times* is not meant to replace LPCC and/or Cluster generated Family or Provider Newsletters. Content in the *Training Times* is specific to the educational needs of First Steps Direct Service Providers, Intake and Service Coordinators.

This inaugural edition includes two articles. *Zero To Three* has granted reprint permission for, “*Understanding and Negotiating Cultural Differences Concerning Early Developmental Competence: The six raisin solution*”. This is an excellent article on understanding cultural diversity. “*Yes, YOU Can—Providing Inclusive Services During Everyday Routines, Activities and Places*” is an original article by Elizabeth Traub and Lois Hutter-Pishgahi from the Indiana Institute on Disability and Community at Indiana University. We hope to continue to offer both original writings and article reprints in future issues. Please let us know when you find a professional journal article that you feel would be of value to other early intervention providers. We will obtain all necessary reprint permission. We also welcome submissions of original articles to the *TRAINING TIMES*.

Just a reminder, all annual training registrations and fees were due December 1, 2004. While the current mailing list was generated from all enrolled providers, future mailings will only be sent to those providers who have submitted their annual training registration form and fee. You will find a self-assessment and evaluation on page 15. Each quarterly newsletter provides two (2) training contact hours which is equivalent to .2 credential points.

To verify your completion of this mandatory training and receive your credential points, First Steps providers must successfully complete and submit the self-assessment to the ProKids office, before February 15, 2005.

We are committed to offering all providers a varied educational menu of topical trainings, newsletters and in the future—online education. Our goal at UTS-Programmatic Training is to provide learning opportunities that meet the unique needs of our First Steps families and early intervention providers.

The staff at UTS-Programmatic Training wishes everyone a happy Holiday Season and New Year.



INDIANA'S UNIFIED TRAINING SYSTEM

“Creating Learning Opportunities for Families and Providers Supporting Young Children”

Bureau of Child Development Updates

- 1) Eligibility Determination (ED) Teams will be expanding throughout the state, with full implementation in every cluster by June 2005. Please contact your LPCC, if you would like to be involved.
- 2) As part of their mandatory training requirements, all enrolled direct service providers, except: Physicians, Optometrists (who do not provide ongoing vision services), Transportation Providers, Interpreters, and Assistive Technology Vendors; are required to complete the quarterly newsletter self-assessment before February 15, 2005. If you are unsure of your status in regards to the mandatory annual training requirements, please contact CRO/Provider Enrollment at (888) 567-2351, option 2. The final component of the new mandatory training requirements for direct service providers is attendance at the designated mandatory cluster meeting, in the cluster where the majority of your services are provided. All providers should have registered for this meeting. Meeting dates and locations are posted on the Early Childhood calendar at: <http://earlychildhoodmeetingplace.indiana.edu/calendar.lasso>
- 3) Intake and Service Coordinators must also complete and submit the self-assessment before February 15, 2005. Other mandatory training requirements for Intake and Service Coordinators are attendance at two (2), half day Regional Service Coordinator meetings (November and May) and attendance at the designated mandatory cluster meeting in the cluster where they work. All Intake and Service Coordinators should have registered for these meetings. Meeting dates and locations are posted on the Early Childhood calendar.
- 4) When an extenuating circumstance causes a provider, Intake or Service Coordinator to miss a mandatory meeting, they **must** email CRO/Provider Enrollment (firststeps@pdainc.com) for make up requirements.
- 5) Cathy Robinson has been hired by the BCD to fill the vacant consultant position. Cathy will be responsible for Clusters 10 and 11. A revised BCD Consultant map with consultant contact information can be found on page 10 of this newsletter.
- 6) It is expected that families will pay their Cost Participation fees. Please encourage families to make their Cost Participation payments. Families with general questions regarding Cost Participation, should contact their Service Coordinator. If they have billing questions, they should contact the CRO.
- 7) The BCD is required to submit an annual performance update to the Office of Special Education Programs (OSEP). The BCD recently received OSEP's response to its 2002-2003 Annual Progress Report (APR). The BCD is now required to develop an improvement plan which will address the timelines in which the IFSP is to be developed (no more than 45 days from referral) and the provision of services within the natural environment. OSEP has clarified that parent choice and/or lack of provider availability are not acceptable reasons for services not being provided in the natural environment. Additional information on providing services in the Natural Environment will be posted on the state web site.
- 8) The BCD continues to focus on transition activities for children, especially as they exit First Steps. Please remember that every child is required to have a transition meeting, regardless of whether the child will attend Part B Preschool Special Education. **This meeting MUST take place 180 to 90 days before the child's 3rd birthday.** If you think of this meeting as a 90 day transition meeting, and you wait until the child is 33 months to schedule it, you are too late.
- 9) During their first year, all newly enrolled Direct Service Providers must attend a half-day Orientation Follow-Up Training. These are scheduled six (6) times throughout the grant year at various locations. Check the Early Childhood Calendar for dates and times.
- 10) The BCD is moving toward direct deposit for payment to all enrolled providers (Direct Service Providers and Services Coordinators). Enrollment forms are posted on the web.

Reminders

- 1) The BCD strives to process prior approval requests within two weeks. There are some situations that require a more thorough review. If you have not received a reply after three weeks, you should email Kelli Plummer at: Kelli.Plummer@fssa.in.gov.
- 2) When submitting billing forms to the CRO, you **must** include the location code on the form. If the CRO continues to receive billing forms with missing location codes, the CRO will begin rejecting claims.
- 3) Providers are required to submit quarterly progress notes for every child they serve. These notes are to be sent to the Service Coordinator. Progress notes for the child's last quarter of service must also be submitted. Timely submission of quarterly reports is being monitored. The BCD will be sending letters to those providers, who do not submit quarterly notes, to notify the provider that they are in violation of their provider contract.
- 4) The state web page address is:
http://www.state.in.us/fssa/first_step/index.html

Understanding and Negotiating Cultural Differences Concerning Early Developmental Competence: *The six raisin solution*

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(www.zerotothree.org).

"I'm so frustrated!" announced Joann as she stormed into her early intervention director's office. "I'm just not getting through to Rosa. I know she's a very loving mother to Maria, but she just doesn't follow through with any of my suggestions. I put Maria in her high chair today and gave her some crackers that I brought. Rosa is always quiet and nods when I tell her how much Maria needs to learn to finger-feed herself, but I know she never lets Maria touch the food when I'm not there. I could hear Rosa running the bath water before I even closed the apartment door today. Why is she so worried about Maria making a little mess? As the occupational therapist, it's my job to help Maria learn to use her hands. Even though Maria's 2 1/2 years old, developmentally she's only about 11 months old. She still puts everything in her mouth, so the only small things we can give her are pieces of food. How can I get Rosa to understand? I know it's not a language issue, because Rosa told me on my first visit that she is from a bilingual family and is as comfortable in English as she is in Spanish. I just don't know what else I can do!"

When our cultural assumptions, beliefs and values are violated, we all react with strong emotions. Shock and a sense of bewilderment often overwhelm us, limiting our responses and generating im-

mense barriers to effective communication. Joann knows she is frustrated. What she does not know is that she has unwittingly violated Rosa's cultural assumptions regarding appropriate child-rearing goals, developmental expectations and parenting practices. Both Joann and Rosa are aware that something is not working in their efforts to help Maria, but neither understands cultural processes well enough to negotiate these barriers to effective collaboration.

This article describes a staff development model that is designed to help practitioners who work with infants, young children and their families build more collaborative and effective cross-cultural relationships. We have tested this model with several groups of practitioners, including regular and special education early childhood teachers and paraprofessionals, as well as physical, occupational, and speech/language therapists. Content of the training is based upon current cultural research (our own and others') that provides insight into cultural variations in parenting and describes culturally diverse pathways to developmental competence. This approach offers practitioners something more than a general belief in the need for "cultural sensitivity" and some limited knowledge of common parenting practices among particular cultural groups. Understanding why

parents and families value particular parenting practices enables practitioners to discuss and negotiate any changes that might further their children's developmental competence respectfully, from within the parents' perspective. Such truly collaborative goal setting is the key to effective early intervention services among the increasingly diverse populations found in the United States today. Our collective failure to understand and respect the cultural beliefs and values of diverse families may help to explain the consistent underutilization of early intervention services by non-European-American minorities nationwide (Arcia & Gallagher, 1993; Arcia, Keyes, Gallagher, & Herrick, 1993; Bennett, Zhang, & Hojnar, 1998).

The processes required to identify, adapt to, and respect diverse pathways to developmental competence form the core components of culturally sensitive practice. Our staff development model includes four workshop sessions presented over a period of about two months. Each presentation lasts about one hour and includes a group activity and facilitated discussion. All staff members are encouraged to participate actively in all aspects of the training and to share personal reflections throughout the training process. We will follow Joann as she participates in this staff development program and begins to build a more collaborative and ef-

fective relationship with Rosa.

Culture as shared knowledge

Joann and her colleagues begin their training by learning to think about culture as shared knowledge about how the world works. We use this cultural knowledge to interpret events and experiences in our lives. Often this cultural knowledge is unspoken or assumed. We become aware of it only when assumptions are violated. Think of your reaction when someone violates your idea of adequate personal space between social partners. Violations of cultural assumptions lead to strong affective responses. Cultural knowledge is based upon our interactions with others and is continually modified in the context of these interactions. For example, New Englanders who move to California may eventually learn to accept a hug instead of a handshake as an appropriate greeting between casual acquaintances. We acquire cultural knowledge through our life experiences and social interactions. Ethnicity is not the same as culture. To the extent that ethnicity contributes to our life experiences and social interactions, it contributes to our cultural knowledge, but so do other important factors such as education, regional characteristics, travel, religious beliefs, membership in particular population cohorts, social-economic status, and work experiences.

Joann began to think about how her education, work experience, family roles, and religion had contributed to her understanding of how the world works. She also thought about how nice it is to meet someone with whom you share many similar life experiences. Friendships are often

based upon such common backgrounds, so that each partner feels almost immediately that she has known the other for a long time. Joann began to understand that the easy sense of comfort and competence which characterizes her work with middle-class Anglo families is a result of the wide variety of life experiences which they share with her. She began to realize that the frequent frustrations and misunderstandings in her work with Rosa might be the result of quite different life experiences and a relative lack of shared knowledge.

Learning to bridge gaps in shared knowledge requires two complementary and ongoing processes: self-awareness of one's own cultural assumptions, values, and beliefs; and willingness to explore the cultural knowledge of others in the full context of their personal and shared histories, assumptions, goals, beliefs, and practices.

It is important to stop here and consider the difference between shared knowledge and cultural agreements among groups of people vs. individual beliefs, values, and practices. Researchers analyze cultural differences between groups based on overall group tendencies. This general knowledge may provide us with a basis for introducing cultural conversations, but it does not tell us about the ways in which members of a group may differ among themselves. We must develop our own personal skills to build self-awareness and promote respectful cultural sharing and exploration with the families we serve.

In order to build a framework for comprehensive understanding of cultural beliefs and values related to parenting, we must first under-

stand a culture's long-term socialization goals for children. Personal awareness begins with thoughtful consideration of the question "What qualities would you like your child (real or hypothetical) to possess when he or she is an adult?" The qualities that we hope to inculcate in our children are windows into the personal and community values that we hold most dear. Current research finds striking patterns of agreement within cultural groups in the choices of long-term socialization goals (Harwood, Schoelmerich, & Handwerker, 1999). For example, although variation within a group always exists, there is a general tendency for members of Anglo groups to emphasize goals related to the maximization of the self (people should be happy, confident, independent, intelligent, and assertive) and to balance these with qualities of lovingness (people should be kind, caring, and compassionate). Similarly, there is a tendency for individuals sharing a Puerto Rican cultural background to emphasize goals related to proper demeanor (people should be respectful, obedient, appreciative, accepted by the community, and fulfill role expectations) (Gonzalez-Ramos, Zayas, & Cohen, 1998; Harwood, Miller, & Lucca Irizarry, 1995; Harwood et al., 1999).

The process of examining personal socialization goals, and then discussing and comparing them with a group of colleagues is extremely enlightening. Rarely are these assumed goals openly discussed, and even more rarely are they analyzed in a manner that facilitates understanding of their inherent potential for enhancing cultural understanding of self and

others. During the second cultural training session in our staff development model, the workshop participants generated a few personal long-term socialization goals, and shared the most important ones with the group. Joann and her colleagues were surprised to see that their collective goals were so strongly clustered in the self-maximization category. Only two of these 20 clinicians mentioned primary personal socialization goals in the proper demeanor category. The workshop facilitator explained that results from a current study of middle-class, Anglo mothers from Connecticut and a similar group of Puerto Rican mothers from San Juan would be used for comparative purposes throughout the training (see Chart 1). When the training group responses were compared with

those of the middle-class Anglo and island Puerto Rican research participants, they found a close match with the Anglo group (Harwood, Schoelmerich, Schulze, & Gonzalez 1999). One participant noticed that, although the Puerto Rican mothers mentioned proper demeanor goals most frequently, their responses were more balanced overall, with many mothers mentioning goals in nearly all categories. Although the research findings used as an example in this training compare middle-class Puerto Rican and Anglo goals, several participants speculated that Russian, Bosnian, Laotian, and Middle-Eastern immigrant parents in their programs might share a similar focus on goals pertaining to respect and family relationships.

During the ensuing discussion of middle-class Anglo emphasis on individual autonomy to the exclusion of other concerns, Joann observed that the list of goals under self-maximization was a good description of our schools. Most educators and therapists are primarily concerned with maximizing each child's individual competence and independence. An older colleague remarked that these goals were not emphasized so strongly in families and schools during the 1940's and 50's. Other over-40 staff members remembered that obedience, respect and good citizenship were very important at home and in school at that time. Joann wondered if perhaps we could learn from other cultures to balance our strong individualism with more attention to the needs of each other in families and communities. Perhaps the growing movement toward social responsibility curricula in schools nationwide represents an emerging understanding of our need to temper individualism with training in proper demeanor and decency.

Joann realized that she would need to understand Rosa's individual socialization goals in order to establish a more respectful, collaborative working relationship. Using strategies discussed in the staff training, Joann began to explore cultural goals with Rosa on her next visit.

Joann: *Rosa, I think it would be very helpful for me to understand more about what kinds of things are most important to you in raising your children. Would you mind talking for a few minutes about what you would like your children to be like when they are adults?*

Rosa: *Sure, I'd like my children to be well-behaved, respectful,*

Socialization goals

In a study of 32 middle-class Anglo mothers living in Connecticut, and 28 middle-class Puerto Rican mothers living in San Juan, Puerto Rico, mothers were asked to describe the qualities they would and would not like to encourage their children to develop as adults. A cluster analysis of mothers' open-ended responses to these interview questions revealed that 84% of the Anglo mothers were classified into one of two clusters emphasizing Self-Maximization and Self-Control, whereas 67% of the Puerto Rican mothers were classified into one of two clusters emphasizing Proper Demeanor and Decency.

Qualities contained in clusters of socialization goal responses:

Self-Maximization

happy, secure, self-confident, healthy, intelligent, successful, independent, assertive

Self Control

greedy, selfish, spoiled, patient, control emotions, vindictive, aggressive, prejudiced

Decency

avoid illegal activities, honest, hardworking, good values, responsible, religious, good citizen

Proper Demeanor

respectful, cooperative with authority, obedient, appreciative, liked by others, fulfill family role expectations

Chart 1

good people who believe in God. I want them to be connected to me, to learn a lot from me. I want to have something very special with them, so that I can bring them up well, so that they will be good to their families, leaders for the next generation.

Joann: So respect, faith and a strong connection to the family are very important to you.

Rosa: Yes, children need to learn to be obedient, studious, and grow up to be hard working. It's also important for children to be gentle, loving with others and attached to their family. My parents raised me to be affectionate and grateful and I work to pass that along to my children also.

Joann: You know, that's a very good point. I think maybe we're so busy teaching our children to be independent and self-confident that we don't spend enough time helping our children to understand the importance of respect and family relationships. Teaching children loving and respectful behaviors so that others will like them is certainly important for their futures. I really appreciate your willingness to share your goals with me. I think it will help us to work together in finding better ways to encourage Maria's development.

Joann felt a sense of accomplishment instead of frustration at the end of this visit. As she shared the conversation about childrearing goals with her director, she felt both proud and excited by this initial success with cultural exploration.

Social networks and developmental expectations

The next staff development session continued to build self-awareness of cultural assump-

tions by exploring the ways in which individuals construct social networks and understand developmental expectations. As staff members wrote lists of weekly activities and social contacts outside the immediate family for their own "hypothetical toddlers," the training leader encouraged them to consider the number and frequency of contacts with relatives as well as non-family members. Most participants listed several weekly toddler group activities such as playgroups, library story hours, Gymboree, or mom-and-tot swimming classes. The majority of these hypothetical toddlers had between zero and two contacts with relatives in the course of a typical week. When asked how these social networks were consistent with their socialization goals, staff members readily pointed out that a variety of social contacts and activities will help toddlers become self-confident, assertive, and independent.

Joann suggested that maybe the reason that Rosa does not attend Birth to Three parent-child playgroups is that these activities do not support her socialization goals. Other participants agreed with Joann and offered confirmation that some Latino families do not seem to be interested in playgroups. The leader congratulated Joann on her insight and offered research results in support of her observation. Children whose parents emphasize goals relating to the self are more likely to experience contacts with a larger number of individuals on a regular basis, and to experience fewer contacts with relatives, even when relatives live nearby. Children whose parents emphasize goals related to proper demeanor and interdependence are likely to

have more frequent contact with a smaller number of individuals, and more frequent contacts with extended family members (Miller & Harwood, 1999)

Joann made a mental note to ask Rosa about her interest in meeting with other parents of children with special needs. Perhaps she would like to share a joint home visit with one other family or attend a small parents-only group. She also planned to let Rosa know that she is welcome to invite any extended family members to participate in home visits, planning meetings, parent groups, or any other Birth to Three activities. And in the future, Joann would be careful to inform families about playgroups without pressuring them to attend.

The group's exploration of developmental expectations began with participants looking at a list of early developmental skills (wave bye-bye, be toilet trained during the day, say first word, etc.) and discussing the expected age of attainment for each. Even though participants were all working as early childhood educators and therapists, a surprising level of disagreement surrounded several milestones. One participant had toilet-trained her children between 18 and 24 months, and reported that they are now happy, well-adjusted high school honor students. Others felt strongly that early toilet training was not acceptable. Responses to the age at which infants/toddlers are able to enjoy other children ranged from 9 to 24 months. Group consensus was reached on only 2 or 3 of the milestones.

This rather heated discussion provided evidence that we all hold our own cultural beliefs in

high regard, and tend to react with defensive emotions when they are challenged. This observation changed the group's focus to our tendency to assume that there is one universally "correct" set of ages at which children should attain developmental milestones. In the past, mothers who were judged as lacking in knowledge of this "correct" timetable were thought to be at risk for poor parenting practices and in need of corrective parenting education.

Coincidentally, many of the mothers who were found to lack knowledge of the "correct" developmental expectations were members of minority cultural groups. Current research that examines mothers and their infants in the full context of their cultural values and beliefs challenges this assumption of a single, universal, correct set of developmental expectations, instead finding evidence of distinct cultural patterning in the everyday activities of infancy.

Mean Age Expectations in Months for Milestone Attainment

	Anglo	Puerto Rican	Filipino	p
Eat Solid Food	8.2	10.1	6.7	a*,c
Training Cup	12.0	17.1	21.9	a,b,c
Utensils	17.7	26.5	32.4	a,b,c*
Finger Food	8.9	9.4	9.5	
Wean	16.8	18.2	36.2	b,c
Sleep by Self	13.8	14.6	38.8	b,c
Sleep all Night	14.4	14.5	32.4	b,c
Choose Clothes	31.1	44.2	33.1	a,c
Dress Self	38.2	44.2	39.2	
Play Alone	25.0	24.8	12.3	b,c
Toilet trained/Day	31.6	29.0	20.4	b,c
Toilet trained/Night	33.2	31.8	34.2	

a = Anglo significantly different from Puerto Rican
 b = Anglo significantly different from Filipino
 c = Puerto Rican significantly different from Filipino
 Note: Unmarked comparisons, p < .01. * p < .05.

Chart 2

Mothers whose socialization goals emphasize proper demeanor and appropriate relatedness expect their infants to attain a variety of milestones at a later age than mothers who emphasize self-maximization goals (Schulze, Harwood, Goebel, & Schubert, 1999). (See Chart 2).

Joann began thinking about Rosa's insistence on spoon-feeding Maria and decided to ask her about developmental expectations.

Joann: Rosa, do you feel that it's important for you to feed Maria because it helps her to feel connected to you?

Rosa: Well, yes. It's important for a little child to know that her mother will always help her, will always be there to take care of her needs. Maria needs a lot of help, and I'm showing her that she can always trust her family to care for her.

Joann: When do you think children in general should be able to feed themselves without help at a family meal?

Rosa: When they are ready to eat calmly and properly using a spoon and fork and showing good table manners. Maybe when they are 4 or 5 years old. It depends on the child.

Joann understood that even though Rosa's expectations were markedly different from her own, they were consistent with Rosa's cultural beliefs and reflected a meaningful focus on her long-term socialization goals. Joann could also see that these goals and expectations would lead to positive developmental outcomes for a typical child in the context of Rosa's home. Joann also suspected that Rosa's children might have better table manners at kindergarten age than Joann's own children!

The pieces of the cultural difference puzzle were beginning to fall into place for Joann

and Rosa. Joann's final task involved considering Maria's individual special needs in the context of her home environment. The fact remained that Maria's developmental delays required out-of-the-ordinary adaptations in her environment to facilitate her development. Maria's use of mouthing as an exploration strategy was likely to continue for quite some time. Helping Maria to refine her raking grasp and begin to isolate her index finger would require manipulating small objects, and food would continue to be the only safe option. Joann decided to try negotiating these issues with Rosa, using some of the strategies and concepts discussed during the staff training sessions and her knowledge of Rosa's goals and expectations.

Joann: Rosa, I think it's very important for us to try to help Maria learn to use her hands and fingers better so that she can learn to pick up small things and play with more complicated toys. I know that feeding her is an important part of your relationship. Can you think of anything small besides food that we could use to teach her this?

Rosa: No, Maria puts everything in her mouth. It's not safe to give her anything small, unless it's something that she can eat.

Joann: Remember when I gave her crackers in her high chair a few weeks ago? You didn't seem to be very comfortable with that.

Rosa: No, I know Maria can't help it, but when she picks them up she smashes and crumbles them. Then the pieces get all stuck on her hands and face and in her hair. I can't stand to see her all messed up like that. She just needs my help to eat crackers and it's important to me to help her.

Joann: If we could find something that she could pick up without

crumbling it all over, would that be easier for you? How about raisins? She won't crumble them, but she will need to work hard with her hands and fingers to pick them up.

Rosa: That's a good idea. I think she likes raisins.

Joann: Could you spread about six raisins around on her tray while she is waiting for you to get her food, and let her try to pick them up one at a time by herself?

Rosa: Yes, that's a good idea. I'll get some raisins at the store tomorrow. By the time you come next week, maybe she'll be able to pick them up and get them in her mouth by herself! It will be more fun for her when she can use her fingers to play with lots of different toys instead of always using baby things.

Needless to say, Joann felt quite triumphant in relating this conversation to her program director. Joann's emerging understanding of culture as a lens through which we interpret events and experiences in our lives had enabled her to overcome the barriers to successful intervention with Maria and her mother.

Effective training for culturally sensitive practice

Finding alternate pathways to developmental competence for children with developmental challenges is the ultimate goal of all early interventionists. Understanding that "developmental competence" is a culturally defined construct is, however, a new experience for many service providers. The staff development model described in the story of Rosa and Joann has been presented to several groups of professionals, including regular and special education early childhood teachers and paraprofessionals, as well as

physical, occupational, and speech/language therapists. The programs represented by these staff members serve typical and special needs children from birth through age six in both classroom and home-based settings. At the conclusion of the training sessions, 95 percent of the participants agreed or strongly agreed with the statement, "I will use the information from this training to change some of the ways in which I work with families."

The two aspects of the training that generated the most responsive interest were the definition and examples of what constitutes culture, and the discussion of long-term socialization goals. Many participants admitted to having always equated culture with ethnicity, and to having used knowledge of group characteristics to make programming assumptions without exploring the cultural beliefs of individual parents and families. During the course of the training, participants came to realize that knowledge of group history and characteristics is valuable, but not sufficient, for culturally sensitive practice. In particular, they appreciated the training emphasis on specific questioning strategies for use in exploring cultural beliefs and values with families, with 95 percent of participants agreeing or strongly agreeing with the statement, "I will use the information about socialization goal categories and questioning strategies in my work with families."

Teaching early intervention and early care professionals that culturally sensitive practice requires awareness of how personal experiences, beliefs, and values influence their own understanding of development is a necessary first step in our journey toward more

inclusive services for infants, toddlers and their families. Teaching service providers to make proactive efforts to gain understanding of each parent's goals and expectations, and to share their own perspectives respectfully, is the next step in this journey. Only after these steps have been taken, and mutually respectful, collaborative relationships with parents established, can service providers begin to successfully negotiate adaptations in parenting and programming practices.

If professionals are not prepared to actively seek the parents' cultural perspectives and share their own, communication will frequently remain unilateral, and the effects of interventions will remain minimal. As Latino, African, and Asian American communities continue to grow in the coming years, the future of our children depends on our understanding of culture and our willingness to engage in personal and professional cultural exploration. As direct service professionals, we must be willing to engage in an active dialogue with cultural researchers -- learning, implementing, and providing feedback to increase our collective effectiveness in including culturally diverse populations in family support and educational programming.

This staff development model represents an effort to bridge the gap between practicing service providers and cultural researchers in anthropology and psychology. The strong, positive reception it has gained in pilot presentations is testimony to the need for and appreciation of such information among current early intervention professionals.

References

Arcia, E., & Gallagher, J. J.

(1993). Who are underserved by early interventionists? Can we tell? *Infant-Toddler Intervention*, 3, 93-100.

Arcia, E., Keyes, L., Gallagher, J. J., & Herrick, H. (1993). National portrait of sociodemographic factors associated with underutilization of services: Relevance to early intervention. *Journal of Early Intervention*, 17(3), 283-297.

Bennett, T., Zhang, C., & Hojnar, L. (1998). Facilitating the full participation of culturally diverse families in the IFSP/IEP process. *Infant-Toddler Intervention*, 8(3), 227-249.

Gonzalez-Ramos, G., Zayas, L. H., & Cohen, E. V. (1998). Child-rearing values of low-income, urban Puerto Rican mothers of preschool children. *Professional Psychology: Research and Practice*, 29(4), 377-382.

Harwood, R. L., Schoelmerich, A., Schulze, & Gonzalez, Z. (1999). Cultural differences in maternal beliefs and behaviors: A study of middle-class Anglo and Puerto Rican mother-infant pairs in four everyday situations. *Child Development*, 70(4), 1005-1016.

Harwood, R. L., Miller, J. G., & Lucca Irizarry, N. L. (1995). Culture and attachment: Perceptions of the child in context. New York: Guilford Press.

Harwood, R. L., Schoelmerich, A., & Handwerker, W. P. (1999). Representing cultural complexity: An examination of mothers' long-term socialization goals in diverse populations. Manuscript submitted for publication.

Miller, A.M. & Harwood, R.L.

(1999). Long-term socialization goals and the construction of infants' social networks among middle-class Anglo and Puerto Rican mothers. Manuscript under review.

Schulze, P.A., Harwood, R.L., Goebel, M.J. & Schubert, A.M. (1999). Cultural influences on mothers' developmental expectations for their children. Poster presented at the Biennial Meeting of the Society for Research in Child Development, Albuquerque, NM.

Hanen Workshop

Involving Parents as Language Facilitators – A 3-Day Hanen Certification Workshop for Speech-Language Pathologists on *It Takes Two to Talk* –The Hanen Program® for Parents.

**June 23, 24 &25, 2005
Indianapolis, IN**

Hosted by ProKids, Inc.

In *Involving Parents as Language Facilitators*, speech-language pathologists also learn to lead *It Takes Two To Talk* — The Hanen Program® for Parents. In this innovative early language intervention program, SLPs teach parents how to promote their children's language development in every day interactions. The goal of this program is to enable parents to become their child's primary language facilitator so that language intervention becomes an ongoing process.

Go to www.Hanen.org for workshop and registration information. Space is limited to 14 participants.

Bureau of Child Development Consultant Coverage Map

FIRST STEPS CLUSTER MAP - 2004/2005

Division of Family and Children/Bureau of Child Development

Consultant Coverage

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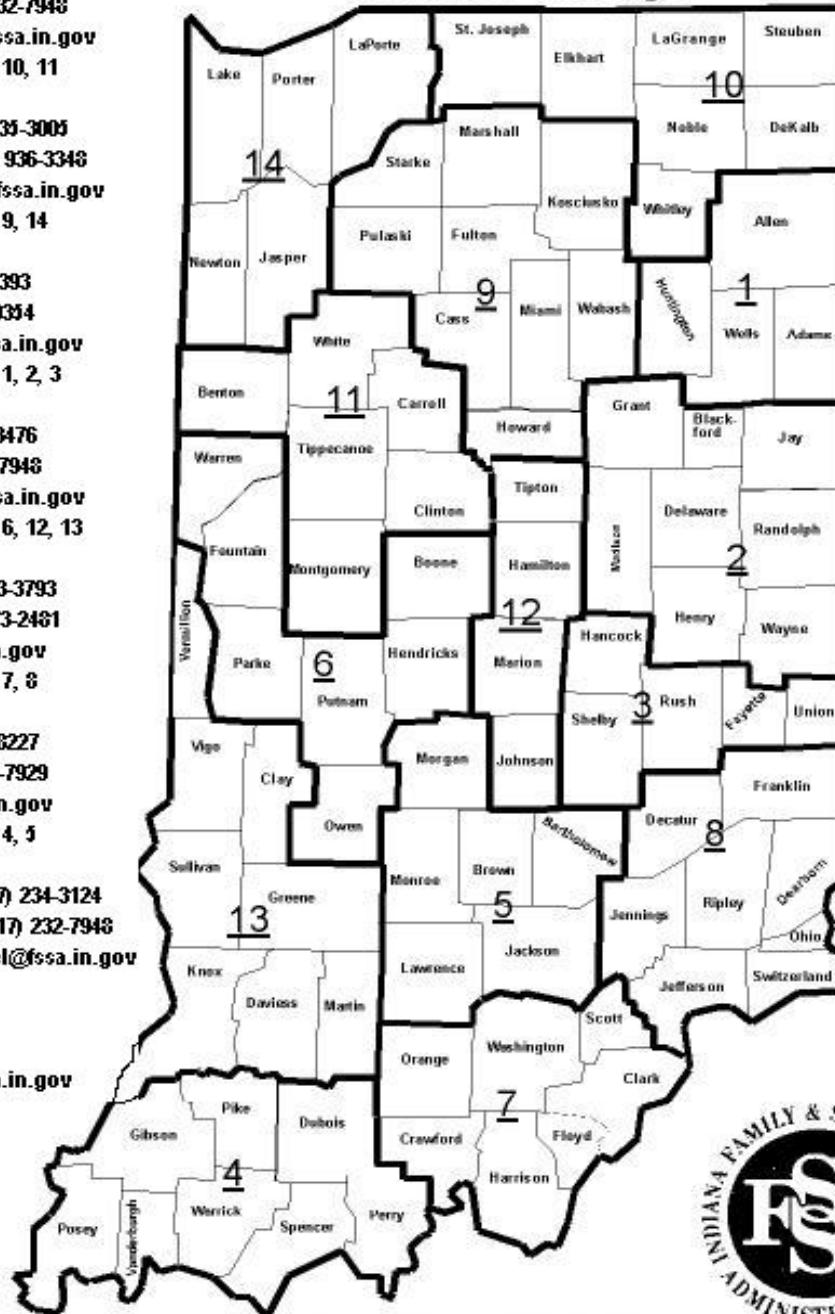
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First Steps Cluster Web Address

Effective - December 1, 2004 http://www.in.gov/fssa/first_step/region.html

KC&K

The above cluster map identifies each BCD consultant, their cluster assignments and their contact information. While consultants welcome your input and questions, it is important to initially address your concern or question to the appropriate local level representative (your supervisor, SC-Regional Point of Contact, SPOE Cluster Supervisor and/or LPCC Coordinator). If the local level representative is unable to help, you should contact your BCD consultant.

Yes YOU Can! Providing Inclusive Services during Everyday Routines, Activities and Places

Elizabeth K. Traub & Lois Hutter-Pishgahi, Indiana Institute on Disability and Community, Indiana University.

Life is complicated but when a family adds another child, especially a child with special needs, it becomes even more complicated and challenging. Fortunately, through the First Steps Early Intervention system, services can now be provided in typical early childhood settings. A family interview and ongoing assessment helps the IFSP team members identify the outcomes a family has for their child.

As the following case story illustrates, flexibility and communication are key to successful outcomes. It is the creativity of these providers along with family participation that will help bring about gains in the child's general development and learning.

Integrated Services for Bobby:

Bobby is a bright happy 2 ½ year old who has cerebral palsy with cognitive and language delay. He is now able to walk slowly with the support of a walker. Bobby's mother Beth is a single parent who works part-time as a lunchtime aide at the local elementary school. During the IFSP meeting, Beth was asked what she most wanted to see happen as the result of early intervention. She expressed frustration over the lack of organization in their lives. Exasperated she said: "I want to be able to do my household activities with less stress on both my part and Bobby's." In response, the team developed the following outcomes:

1. Beth will work with EI providers to identify ways to include Bobby in the typical daily family routines (e.g. laundry, grocery, church);
2. Bobby will learn to communicate his interest in participating in an activity through use of body language. (e.g. head movement, eye blinking, smiling);
3. Bobby will have opportunities to interact with peers in community settings such as child care, church nursery, and other typical community environments where children can be found (e.g. fast food restaurants, grocery stores, Laundromats, etc.).

Now let's consider a typical visit by Bobby's occupational therapist, Sam. Sam asks what the plans are for the day and Beth explains that she really needs to get some laundry done. She is hoping they can go to the Laundromat together. She adds that she doesn't typically take Bobby to the Laundromat because he usually fusses and demands her

attention the entire time. So Sam spends some time engaged in problem-solving and planning with Beth so that she can figure out how to get the laundry done and keep Bobby happy and occupied. The following are examples of some of these questions and solutions. 1) What do we hope to accomplish? (Three loads of laundry, and to read a few books with Bobby and play with some toys); 2) What will we need to take with us in order to make this a successful outing for everyone? (Some books and toys, snacks, and Bobby's adaptive seating equipment)

Sam helps Bobby get dressed while Beth gathers things for their outing. Bobby gets to choose between two outfits and then Sam talks aloud through a game he plays with Bobby while helping him through exercises suggested by the physical therapist. He comments about how Beth might look for other opportunities to play similar games during regular dressing routines.

Beth appreciates Sam's help getting things into the car. As she puts Bobby in the car seat, Sam asks questions and makes suggestions about helping Bobby relax so he fits securely in the seat. Because Sam has another appointment and will have to leave before the laundry is finished, they will drive separately.

At the Laundromat, Beth places Bobby into his adapted stroller and carries in the first basket of clothes. Sam suggests that Bobby help her put some of the clothing in the washer. Bobby is thrilled to be able to participate, and with Sam's help, it becomes a game. Soon the first load is in the washer.

When Bobby tires of the laundry game, Beth brings out a book about clothes for him to look at. Sam talks her through placement of the book on his tray and how to get the best response from Bobby. They start to look at the pictures and try to find the same article of clothing in their own laundry basket. When Beth finds an article in the book and picks up an item in the basket, Bobby smiles or nods his head in recognition, or frowns when she plays a trick and chooses the wrong one.

Beth talks about the people in the book and how they seem to feel (labeling emotions) and identifies some of the colors in the laundry. Sam comments now and then and offers suggestions for expanding the learning opportunity.

Another child who is at the Laundromat with his mother comes over to see what all the fun is about. Beth introduces Bobby and asks the newcomer if he wants to play with Bobby and a toy she has brought along. Bobby is very excited at having another playmate. Sam spends some time showing the little boy how to play and take turns with Bobby.

Before Sam leaves, he and Beth talk about how she will follow-up with some of his suggestions. He will check back with her the following week. Bobby is anxious to get back to his “job” of sorting laundry and uses facial expressions (eye gaze, smiling, etc.) to help his Mom put clothes in the proper pile. Bobby’s new friend plays along too.

Recent Research: What Integrated Therapy looked like in our study

Recent inclusion research conducted by the Early Childhood Center at the Indiana Institute on Disability and Community, Indiana University, identified several elements that contributed to the successful inclusion of young children with significant disabilities. We expected to see children who were full participants in their settings and receiving all services within their community environment. More than thirty early intervention and early childhood special education therapists and teachers, early childhood education staff and parents participated in the research. One of the key elements present in successful inclusion was the provision of therapeutic interventions within typical community settings.

We know that the inclusion of infants and young children with disabilities may require specialized services and the combined expertise of numerous professionals. The coordination of both people and services is essential to providing effective, inclusive services. Inclusive therapy services emphasize teaching and learning within the context of functional daily routines as described in *the case story*.

In the IU study, and *as highlighted in the case story*, we found that *how* therapy services were provided, along with a positive attitude about inclusion, a willingness to communicate and flexibility of providers’ schedules (the person providing therapy) were important factors in the successful inclusion of these young children.

What Integrated Therapy looks like according to the Literature:

The coordination of both people and services is essential to providing good, inclusive services for children with significant disabilities (Bruder, 2001). Therapy services may be described in a continuum: Integrated services provided within home, community or classroom routines to more segregated services provided individually, outside of the child’s typical routines. In addition, there are several critical dimensions to consider: location and involvement of other children, adult-child initiations, routines, goal functionality, and the consultant’s role. Each of these dimensions may also be considered along the continuum of integrated to segregated services (McWilliam, 1995). When therapy is provided in the classroom it has been found that teachers and specialists consult with each other four times as much as when therapy is provided out of the class (McWilliam & Scott, 2001). Therefore, we typically think of integrated services in relation to inclusive settings where specialists, parents and teachers are working together and have more opportunities to consult with one another. The principles of inclusion, developmentally appropriate practice, individualization, and collaboration all suggest that integrated services are preferable to segregated services. “Until conclusive evidence is found to support pull-out therapy that involves minimal contact with classroom teachers, integrated therapy is more compatible with current philosophical trends in early intervention” (McWilliam, 1996, p. 100).

Therapy provided within inclusive environments is further enhanced by effective communication and an understanding and flexibility about the role of each person on the child’s team (Scott, McWilliam, & Mayhew, 1999). “Working collaboratively with the teacher in therapy or instruction and weaving the therapy or instruction into everyday routines might be the most critical aspects of service delivery” (McWilliam, 1995, p. 33).

The mode of therapy also contributes to the successful attainment of outcomes. Therapists in the IU study commented that it made more sense to work on a skill at a time during the routine when other children were participating in the same type of activity (e.g. working on feeding at snack time, practicing social skills during play activities, etc.). The following approaches have been observed or discussed with various First Steps therapists and were also part of the research findings:

Therapy Embedded/Individualized Within Routines.

Therapists work with children during ongoing family, community or classroom routines because they believe the child works harder and benefits more from therapy during those times. As one therapist involved

with the study notes:

“With (child), if we’re in the group setting I get a lot more accomplished. He likes it. It’s easier for him because if you take him out one-on-one, he hates it. He’s going to fight you the whole time. But if you get in that group setting, he’s participating with the other kids. And you do activities that the other kids are doing, he doesn’t realize that it’s work. It’s what everybody else is doing.”

This mode of therapy enables therapists to assess the child’s skills within the context of how the skill is typically used. It also allows skills to be taught in context and provides an opportunity for therapists to demonstrate the recommended strategies and get feedback from parents or teachers. Finally, this mode of therapy encourages and supports the involvement of peers. Therapists realize the value of having other children present for motivation or modeling during therapy routines.

Consultative.

With the parents, teacher and other members of the IFSP team, therapists identify the child’s needs and together develop strategies to address those needs. Therapists provide an effective model of how to work with children to enhance the parents and other provider’s sense of competence and success. The therapist may only work directly with the child for demonstration and assessment purposes, as needed. Later, parents and the other providers are able to address those IFSP outcomes outside of direct therapy and within the daily routine.

Co-treatment.

Therapists most often support the idea of co-treatment when the child has intense needs, or when the child will benefit from two types of therapy at the same time. In all instances, the parent or teacher should be part of the conversation so that strategies can be transferred to other routines.

Individual Flexibility

In the IU research, the therapists interviewed approached their jobs with very flexible ideas about their role as well as the roles of other team members. This flexibility is critical to the effectiveness of the team.

Therapists did not see themselves as having the ultimate knowledge or as always having the answers. They relied on and respected the ideas,

opinions, and knowledge of parents, teachers and other team members.

Therapists saw themselves as part of the team and helped out when they were needed in the classroom, child care setting, or home.

Therapists attempted to be flexible about their schedules so they could be with the child at times that were best for working on specific skills within routines.

Summary

Home, community and early childhood care and education settings that successfully include young children with special needs most often provide therapy services that allow children to work on outcomes during the typical family routines and activities of the day. These integrated therapy services are most effective in settings where family and team members see themselves as equally responsible and valuable in helping a child meet IFSP outcomes. With flexibility, effective communication and an integrated therapy approach, this team of people can work together to provide effective and efficient therapeutic interventions for young children.

References

- Bruder, M. B. (2001). Inclusion of infants and toddlers: Outcomes and ecology. In M. J. Guralnick (Ed.), *Early childhood inclusion: Focus on change* (pp. 203-228). Baltimore, MD: Paul H. Brookes.
- McWilliam, R. A. (1995). Integration of therapy and consultative special education: A continuum in early intervention. *Infants and Young Children*, 7(4), 29-38.
- McWilliam, R. A. (1996). *Rethinking pull-out services in early intervention: A professional resource*. Baltimore: Paul H. Brookes.
- McWilliam, R. A., & Scott, S. (2001, November). Integrating therapy into the classroom. *Individualizing Inclusion in Child Care*, 1-6.
- Scott, S., McWilliam, R. A., & Mayhew, L. (1999). Integrating therapies into the classroom. *Young Exceptional Children*, 2(3), 15-24.
- Smith, B. J., & Rapport, M. J. K. (2001). Public policy in early childhood inclusion: Necessary but not sufficient. In M. J. Guralnick (Ed.), *Early childhood inclusion: Focus on change* (pp. 49-68). Baltimore: Paul H. Brookes.

UTS Programmatic Training - Year One Update

UTS-Programmatic Training moved to ProKids, Inc. in October of 2003. Since that time, we have worked hard to provide a seamless transition of the required core trainings (First Steps Orientation, Service Coordination Level I and Level II, Quarterly Regional Service Coordinator Meetings and Semi-Annual Provider Forums with topical trainings); a full day conference featuring M'Lisa Shelden and Dathan Rush; and collaborations with the Early Childhood Conference and the Bureau of Child Development Institute to sponsor regional and national speakers. We successfully met our grant outcomes for 2003-2004. For most of the year, this was accomplished with two fulltime equivalent staff members and a dedicated group of associate trainers.

UTS-Programmatic Training provided 124 training days with approximately 6,400 attendees. Funding for UTS Programmatic Training is provided by FSSA grant funds and registration fees. FSSA through the Bureau of Child Development provided funding for 62% of expenditures, with the balance funded through participant registration fees (38%).

For the 2004-2005 UTS Programmatic Training year, 57% of expenses will be provided from the BCD grant and 43% from registration fees. The annual mandatory training fee you pay funds not only the training newsletter and mandatory cluster/service coordinator meetings, it also provides funds for core training, curriculum revisions and the development of new training—including the UTS web page and future online course development. You can check our progress at: www.UTSPROKIDS.org.

Directions for Completion of the Self-Assessment

All First Steps Intake/Service Coordinators and all Direct Service Providers (except for Physicians, Optometrists (who do not provide ongoing vision services), Interpreters, Transportation Providers and Assistive Technology Vendors), are required to read the **Training Times**, complete the self-assessment on page 15 and return it to the ProKids office. Intake/Service Coordinators and Providers will receive 2 contact hours (0.2 credential points) for successfully completing this activity.

Complete all sections of Page 16. Answer each question true or false, by legibly marking a T or F in the space provided. Detach page 16 and mail it by February 15, 2005 to: **UTS—TRAINING TIMES; 2511 East 46th Street, Suite E-1, Indianapolis, IN 46205. No credential points will be awarded if you fail to obtain an 80% score or if you miss the self-assessment deadline.**

Annually Intake/Service Coordinators can receive 1.6 credential points for mandatory training activities (**Training Times**—.2 x 4 = .8; Intake/Service Coordinator Regional Meetings .3 x 2 = .6; and the local Cluster meeting—.2). An additional 1.4 points are required for your re-credential (1.0 can be earned for a year of fulltime employment, leaving .4 credential points or 4 hours in other related training).

Annually Direct Service Providers can receive 1.0 credential points for mandatory training activities (**Training Times**—.2 x 4 = .8; and the local Cluster meeting—.2). An additional 2 points are required for your re-credential (1.0 can be earned for a year of fulltime employment, leaving 1 credential point or 10 hours in other related training).

The additional related training can come from your professional associations, affiliated hospitals, clinics or agencies, locally provided training from your LPCC or SPOE, UTS Topical Trainings, Early Childhood Conference or other professional conferences. The choice is yours.

Self-Assessment and Evaluation

T—True F—False Questions for Understanding and Negotiating Cultural Differences:

- _____ 1. Underutilization of early intervention services by minority families may be explained by a collective failure of professionals to understand and respect the cultural beliefs and values of the children/families they serve.
- _____ 2. One need not be aware of their own cultural assumptions, values and beliefs to understand those of the families they serve.
- _____ 3. Puerto Rican families tend to recognize demeanor goals for their children (respect, obedience, appreciation an community acceptance) over the Anglo's emphasis on maximization of self (happy, confident, independent, intelligent).
- _____ 4. The age expectations for self-care milestone attainment is not significantly different among various cultures.
- _____ 5. When professionals do not seek the parents' cultural perspective and share their own, communication remains unilateral and the effects of interventions will be minimal.

Questions for Yes YOU can article:

- _____ 1. The First Steps provider is limited to serving the child in the home or in a community childcare.
- _____ 2. One-on-one services are the best way to provide services to young children with special needs.
- _____ 3. When therapy is provided in the classroom, it has been found that teachers and specialists consult with each other four times as much, as when therapy is provided out of the class.
- _____ 4. Modeling and coaching are two of the strategies that providers can use to educate parents about how to work toward child and family outcomes.
- _____ 5. Understanding the needs of a child requires input from all those involved with the child.

General Questions

- _____ 1. Direct Service Providers, except those listed as exempt, must complete four (4) Training Newsletter Assessments and attend a designated, Annual Cluster meeting in the cluster where they provide the majority of their services, to meet the mandatory training requirements.
- _____ 2. Intake/Service Coordinators must attend two half-day Regional Service Coordinator meetings and a designated Annual Cluster meeting to meet their mandatory training requirements.
- _____ 3. Transition meetings are required for all children in First Steps and should be held after the child is 30 months, but before the child turns 33 months.
- _____ 4. Lack of an available Speech Language Pathologist in a rural area is an acceptable justification for on-site services.
- _____ 5. Families who have questions regarding their cost participation should consult with their Service Coordinator.
- _____ 6. Direct Service Providers can be dis-enrolled for failure to submit quarterly progress reports to the Service Coordinator.

Registration Information: Registration Deadline: February 15, 2005 Contact hours: 2 Credential Points 0.2
Mail this page to: UTS Training Times; 2511 E. 46th Street, Suite E-1; Indianapolis, IN 46205

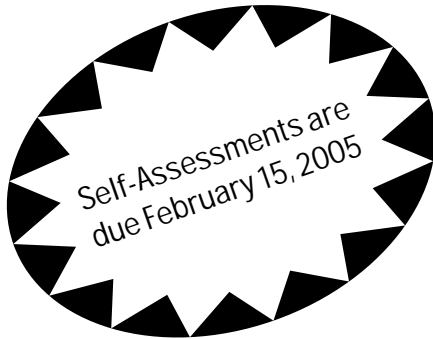
Last Name: _____ First Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____ Email: _____
 Discipline: _____ \$60 Annual Training Fee Paid Yes ___ No ___ check enclosed

Evaluation: Read each statement and circle your response. SD-strongly disagree D-disagree A-agree SA-strongly agree

- | | | | | |
|---|----|---|---|----|
| 1. This home study format is an effective way to present training material. | SD | D | A | SA |
| 2. The training content is relevant to my practice. | SD | D | A | SA |
| 3. The training content met my learning needs. | SD | D | A | SA |
| 4. The self-assessment is a valid measure of what I learned. | SD | D | A | SA |
5. How long did it take you to complete this activity? _____hours _____minutes
6. Suggestions for future topics: _____
7. Other comments about this training activity: _____

UTS Programmatic Training
ProKids, Inc.
2511 East 46th Street Suite E-1
Indianapolis, IN 46205

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Training Calendar Highlights

You can learn more about any of these trainings at <http://earlychildhoodmeetingplace.indiana.edu/calendar/lasso>

December 10, 2004	Spasticity in Children; Causes and Treatment	Indianapolis, IN
February 4, 2005	Augmentative Communication	Shelbyville, IN
February 28, 2005	Child Abuse and Neglect	Indianapolis, IN
March 4, 2005	Autism Spectrum Disorders	Carmel, IN
April 1, 2005	Environmental Factors in Social/Emotional Development	Plymouth, IN
April 14, 2005	How literacy Can Facilitate Sitting, Standing, Jumping...	Muncie, IN
August 20, 2005	L. Edelman - Changing The Way We Think About Change	Indianapolis, IN

2005 Indiana Early Childhood Conference

The Indiana Association for the Education of Young Children (IAEYC) will host the **2005 Indiana Early Childhood Conference, March 17-19, 2005** at the Indiana Convention Center in Indianapolis. Supporting the conference theme "Together We Are More for the Children", attendees, presenters, and exhibitors from across the United States will be in attendance.

The conference presents **over 200 workshops** covering topics such as equity and diversity, exceptional children, family child care, infants and toddlers, leadership, parenting and families, preschool and primary education, research from the field, and health & safety topics.

IAEYC is currently accepting proposals for the 2005 conference. Professionals with experience, knowledge, and the desire to contribute a little extra to improve the lives of children should visit the IAEYC Web site at www.iaeyc.org and click on "Conferences" to submit a workshop proposal. **Experienced, enthusiastic presenters energize and educate professionals directly benefiting the early care and education profession.**

Pre-registration for the Indiana Early Childhood Conference will be available online at www.iaeyc.org or by mail-in registration on or before January 1, 2005. For more information regarding conference prices, event schedules, registration forms, or receiving a preliminary conference program, please contact the Indiana Association for the Education of Young Children at (800) 657-7577, e-mail conference@iaeyc.org, or visit www.iaeyc.org.