



# TRAINING TIMES

First Steps

Volume 1 Issue 4

September/October 2005

## A Quick Look Inside....

- In August, Larry Edelman, a nationally recognized speaker and consultant on family-centered services and change theories presented a one day conference for First Steps providers and families. His words were inspirational to most, while at the same time somewhat concerning to providers who continue to practice exclusively in the medical model. Larry presented research based, **infant**–toddler services that focus on the family as much as the child. With his permission, we have reprinted two of his handouts; *A Relationship Approach to Early Intervention* and *Principles and Strategies for Family-Centered Home-Based Services*.
- Edelman’s work compliments the Early Childhood Outcome Center’s Child and Family Outcomes Development Study. This project is supported by the Office of Special Education and the outcomes developed will be used in State Performance Plans to hold states accountable for achieving child and family outcomes. The article states, “For children, the ultimate goal of this support is to enable young children to be active and successful participants during the early childhood years and in the future in a variety of settings – in their homes with their families, in child care, preschool or school programs, and in the community. For families, the ultimate goal is to enable families to provide care for their child and have the resources they need to participate in their own desired family and community activities.” The ongoing development of child/family outcomes will have a significant impact on early intervention services and supports that are provided to children and families.
- We received feedback that some of the information and questions on Transition (from the June edition of the *Training Times*), was not as clear as it should have been—we apologize for any confusion. A clarification is printed on page 2.
- An exciting, full day conference, especially for Service Coordinators is planned for November 7, 2005. See page 2 for additional information.

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INDIANA’S UNIFIED TRAINING SYSTEM

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

# First Steps System Updates & Information

1. The Regional Service Coordinator meetings for October/November 2005 have been postponed until February/March 2006. Legislative rule changes for eligibility and cost participation should be finalized and ready for implementation, then. It is anticipated that a **full day** of training will be needed. Dates, times and locations will be posted on the early childhood meeting place and the First Steps web page.
2. The Central Reimbursement Office (CRO) is moving from COVANSYS to EDS on February 1, 2006. The state will continue to pay providers and then chase payments from Medicaid, insurance and cost participation. The EDS CRO will be web based. Training for SPOEs will take place in January, with provider training to follow. Watch the What's New area of the First Steps web page for details. **If you have not yet enrolled as a Medicaid provider, you are encouraged to do so ASAP.** Only enrolled Medicaid providers will be able to continue to provide First Steps services. **Direct deposit is mandatory for the new CRO.** If you have not completed your direct deposit forms and submitted them, you must do so—ASAP. The form can be found on the state web page under Links on the right side at: [http://www.in.gov/fssa/first\\_step/index.html](http://www.in.gov/fssa/first_step/index.html)
3. First Steps services for children enrolled in Medicaid Managed Care Organizations will continue to be a "carve out". This means that MCO approval of the IFSP services is not required. The CRO will bill Medicaid directly.
4. First Steps rates are still being reviewed. Lora Miller has announced that there will not be reductions across the board, as rumored. The state is looking at Medicaid Home Care rates.
5. Lora Miller announced that the First Steps Consultants will be moving in-house (in the state office building) effective November 1, 2005. She is aware that this may create a hardship for consultants who live a significant distance from Indianapolis and acknowledges that some may opt not to move. While she regrets the possibility of losing some consultants, she feels that staff restructuring is necessary to complete the work required. Lora invites your comments on how consultants can be most effectively utilized. You may email her from the **How To Contact Us** on the state web page.

## Topics in Service Coordination

Monday, November 7, 2005

8:30—4:00 PM

Indiana Wesleyan  
Indianapolis, IN

This one day conference is geared for First Steps Intake/Service Coordinators. Participants will be able to select one morning and afternoon session according to their interest and needs. Participants will also enjoy a catered lunch with guest speaker Lori Borgman. More information is available on the early childhood meeting place at:

<http://earlychildhoodmeetingplace.indiana.edu>

6. **Clarification on Transition from Part C to Part B—** With parent approval, the Part B representative should always be invited to the Transition Meeting. Service Coordinators should contact the Part B representative for possible dates and times that the Part B representative could attend, before scheduling this meeting with the family and providers. It is important for families to understand what services may be available through Part B and how to access them, even if they are not sure they want Part B services and/or whether the child may qualify for Part B services. The transition meeting must take place at least 90 days before the child's third birthday, and not more than 6 months (180 days) before the child's third birthday. This timeframe will soon be increased to nine months before the child's third birthday with the 2004 reauthorization of IDEA. If your area is experiencing communication problems between Part C and Part B, you should contact the Transition Initiative Coordinator—Mary Jo Palidino ([mpaladin@indiana.edu](mailto:mpaladin@indiana.edu)) and/or your LPCC. LPCC Transition Teams encourage good communication between all parties.

Indiana First Steps

Training Times

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# REGISTRATION FORM

*\*\* Creating learning opportunities for families and providers supporting young children \*\**

**Make check payable to:**  
**ProKids, Inc.**  
**Mail registration with check to:**  
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 Indianapolis, IN 46205  
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 317-472-5602 or 877-434-6085  
**FAX #: 317-205-2592**  
**Use the above address to:**  
 Add, update, or remove your name  
 from the mailing list.  
**Email: [training@utsprokids.org](mailto:training@utsprokids.org)**  
**Registration fees are non-refundable.**

Name: \_\_\_\_\_

Email address: \_\_\_\_\_ (required for confirmation)

Driver's License # (DLN): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (required if paying by personal check)

Organization/Agency Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

(W) \_\_\_\_\_ (FAX) \_\_\_\_\_

I have a child(ren) in:  First Steps  Public School Special Education

Name of Training Event: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Date Payment Rec'd: \_\_\_\_\_

Mailed Packet: \_\_\_\_\_

Date Certificate Issued: \_\_\_\_\_

Certificate Replaced: \_\_\_\_\_

\$5.00 Rec'd. \_\_\_\_\_

Date of Event(s): \_\_\_\_\_ Location of Event: \_\_\_\_\_

**Orientation to First Steps–Independent Study-\$50.00 - check payable to ProKids, Inc.**  
 Fee, if required, is enclosed: Amount: \$ \_\_\_\_\_ Check # \_\_\_\_\_  
 Credit card Info: \_\_\_VISA \_\_\_MC Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

- Special needs or accommodations are: \_\_\_\_\_
- Requesting Family Financial Assistance application
- Requesting information about earning graduate credit in Early Childhood Special Education at Indiana University – Bloomington – for UTS trainings sessions attended.

**DEMOGRAPHIC CATEGORIES:** If you are a first time registrant, or need to update your demographics information, please continue: Place an X in Age Focus, Agency, and Occupation categories that relate to you. Under the Occupation category, identify the specific type under the corresponding category. This information is reported to our funding agencies.

<b>• Age Focus</b>	<b>• Occupation</b>	<b>• Family Type</b>
<input type="radio"/> Infant / Toddler		<input type="radio"/> Foster Parent
<input type="radio"/> Early Childhood	<input type="radio"/> Provider	<input type="radio"/> Grandparent
<input type="radio"/> Preschool		<input type="radio"/> Surrogate Parent
<input type="radio"/> Life Span	<input type="radio"/> Adaptive PE	<input type="radio"/> Parent of child w/special needs
	<input type="radio"/> Advocate	
	<input type="radio"/> Assistive Technology	<b>• Government Type</b>
<b>• Agency</b>	<input type="radio"/> Audiologist	<input type="radio"/> First Steps Coordinator
<input type="radio"/> Advocacy	<input type="radio"/> Child Care	<input type="radio"/> Legislator
<input type="radio"/> Child Care	<input type="radio"/> Developmental Therapist	<input type="radio"/> LPCC
<input type="radio"/> D.D. Center	<input type="radio"/> Dietician	<input type="radio"/> State Employer
<input type="radio"/> Department of Education	<input type="radio"/> Early Interventionist	<input type="radio"/> State ICC
<input type="radio"/> Department of Health	<input type="radio"/> Family Support Specialist	<input type="radio"/> System Point of Entry
<input type="radio"/> FSSA	<input type="radio"/> Independent	<b>• Administrator Type</b>
<input type="radio"/> Head Start	<input type="radio"/> Intake Coordinator	<input type="radio"/> Building Principal
<input type="radio"/> Higher Education	<input type="radio"/> Nurse	<input type="radio"/> Director
<input type="radio"/> Hospital	<input type="radio"/> Occupational Therapist	<input type="radio"/> Disability Coordinator
<input type="radio"/> Maternal Child Health	<input type="radio"/> Paraprofessional	<input type="radio"/> Pre-school Coordinator
<input type="radio"/> Mental Health	<input type="radio"/> Physical Therapist	<input type="radio"/> Program Coordinator
<input type="radio"/> Parent Organization	<input type="radio"/> Physician	<input type="radio"/> Special Educ. Director
<input type="radio"/> Political Organization	<input type="radio"/> Psychologist	<input type="radio"/> Other
<input type="radio"/> Private School	<input type="radio"/> Respite/Home Health Aide	<b>• Training Resource Type</b>
<input type="radio"/> Professional Organization	<input type="radio"/> Service Coordinator	<input type="radio"/> College / University
<input type="radio"/> Public Health	<input type="radio"/> Social Worker	<input type="radio"/> Consultant
<input type="radio"/> Public School	<input type="radio"/> Speech Therapist	<input type="radio"/> Parent Organization
<input type="radio"/> Rehabilitation Center	<input type="radio"/> Teacher	<input type="radio"/> Other
<input type="radio"/> Other	<input type="radio"/> Other	

# Feature Article

## A Relationship-Based Approach to Early Intervention

By Larry Edelman, MS

From time to time, new terms are introduced that describe important aspects of providing early intervention supports and services to young children with developmental delays and disabilities and their families. Concepts such as *natural environments* and *primary service provider* have added new meaning to our work. Recently, the term *relationship-based* has been used to describe an essential dimension of early intervention. The purpose of this article is to review pertinent literature and highlight the rationale and opportunities for taking a relationship-based approach when providing early intervention services.

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“Relationships matter critically. Consistent relationships with caring adults are essential for healthy development” (National Scientific Council on the Developing Child, 2004, p. 5).

“All learning takes place in the context of relationships and is critically affected by the quality of those relationships” (Norman-Murch, 1996).

Over the past several decades, a wealth of research in the science of early development has led to widespread recognition that relationships are critical to development.

“Human relationships, and the effects of relationships on relationships, are the building blocks of healthy development” (National Research Council, 2000, p. 4).

A landmark study documented in *From Neurons to Neighborhoods: The Science of Early Childhood Development* summarized the voluminous research from the science of early development. A core conclusion of the study was,

“The essential features of the environment that influence children’s development are their relationships with the important people in their lives – beginning with their parents and other family members, and extending outward to include child care providers, teachers, and coaches—within the places to which they are exposed – from playgrounds to libraries to schools to soccer leagues.” (National Scientific Council on the Developing Child, 2004, p. 4).

For decades, the critical nature of relationships in supporting child development has been a major organizing principle for the study of infant mental health, social and emotional development, and vulnerable families. In recent years, this focus has also been applied to the field of early intervention for young children with developmental delays and disabilities and their families (Kalmanson & Seligman, 1992; Weston et al, 1997; Greenspan et al, 1998; Miller & Hanft, 1998; McCollum et al, 2001; Wilcox & Weber, 2001; Pilkington & Malinowski, 2002; Gilkerson & Taylor Ritzler, in press). Current early intervention practice recognizes that children’s relationships with their parents and other consistent caregivers are critical to development. Early intervention practices also reflect the importance of relationships between practitioners and parents.

Relationship-based practices in early intervention are aimed at supporting parent-child relationships. A number of skills are needed to infuse relationship-based practices in early intervention. Competence in one’s own discipline is required, but is not sufficient. During a recent pilot project that explored how to support and sustain relationship-based, reflective practice in a large service delivery system, a number of practice skills were identified and used in training staff. These skills in relationship-based early intervention included the capacity to: 1) listen carefully; 2) demonstrate concern and empathy; 3) promote reflection; 4) observe and highlight the parent/child relationship; 5) respect role boundaries; 6) respond thoughtfully in emotionally intense interactions; and 7) understand, regulate, and use one’s own feelings (Gilkerson & Taylor Ritzler, in press). These skills apply to relationships on a number of different levels, both with families, within programs, and across organizations.

Older models of early intervention focused almost exclusively on what was done with a child. Increasingly, relationship-based approaches have practitioners working closely with a child *and* their parents together (Westin et al, 1997; Miller & Hanft, 1998; Kelly, 1999; McCollum et al, 2001; Wilcox & Weber, 2001; Pilkington & Malinowski, 2002; Gilkerson & Taylor Ritzler, in press). Relationship-based early intervention has been described as intervention that is primarily concerned with fostering growth-producing parent-practitioner and parent-child relationships (Kelly, 1999). But the early intervention field has also been recog-

nizing that, in addition to parent-child and practitioner-parent relationships, a number of other relationships (such as *practitioner-practitioner* and *supervisor-practitioner*) are crucial to the effective delivery of supports and services that support children's and families' wellbeing (Weston et al, 1997; Wilcox & Weber, 2001; Pilkington & Malinowski, 2002; Gilkerson & Taylor Ritzler, in press).

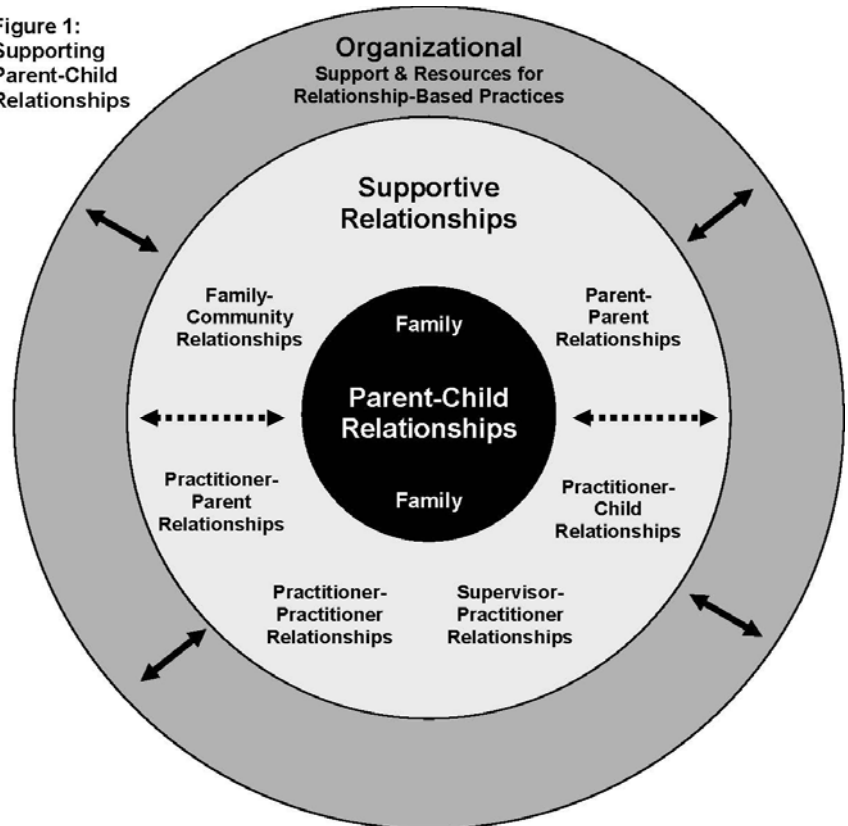
By recognizing and nurturing the many interrelated relationships associated with early intervention, programs can achieve a high level of service delivery in which children participate, learn, and develop in context of their everyday routines, activities, places, and relationships. Figure 1 illustrates how supportive relationships occur on many levels. The discussion that follows describes a few examples of these relationships in order to illustrate how important each one is, and how each relationship can affect the others. It is the sum of these interrelated relationships that create a web of support for children, their families, and those who support them.

### Parent-Child Relationships

“Young children establish and can benefit greatly from a variety of close relationships. Yet those adults who are most consistently available and committed to the child's well-being play a special role in promoting competence and adaptation that cannot be replaced by individuals who are present less consistently or whose emotional commitment is not unconditional” (National Research Council, 2000, p. 389).

The central focus on parent-child relationships in early intervention is in large part based on research findings on early development. There is a growing body of literature that emphasizes the importance of the parent-child relationship for all domains of development (Kalmanson & Seligman, 1992; Weston, et al, 1997; McCollum et al, 2001). An infant's strong, enduring relationship with a primary caregiver provides the infant with a sense of security and identity that is the foundation for a lifetime of relationships (Vacca, 2001). Children's development is affected by the quality of parent-child interactions, family-orchestrated child experiences, and providing for the health and safety of children (Guralnick, 2001).

Figure 1:  
Supporting  
Parent-Child  
Relationships



“Several decades ago British pediatrician and psychoanalyst Donald Winnicott shocked his colleagues by declaring “There is no such thing as a baby” -- only a baby and someone. Today, parents, practitioners, and researchers take it for granted that in order to understand the unfolding of developmental processes, one must look at the infant in the context of his environment and, most particularly, in the context of his relationships with the caregivers in his life” (Fenichel & Eggbeer, (1990).

The explosion of research in early development over the past couple of decades has illuminated that infants have many “preprogrammed” social and emotional abilities (Kalmanson & Seligman, 1992). These abilities include an early preference for human faces over other objects and recognizing their mothers' voices right after birth. So, as it turns out, humans are social creatures--nurturing and stable relationships with caring adults are essential to healthy human development beginning from birth (NSCDC, 2004; Greenspan et al, 1998). As Kalmanson & Seligman found, “Currently, these findings and others have converged in a general consensus among infant clinician-researchers that relationships are the organizing focus of all early development” (1992, p. 47).

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The implications are explicit – parent-child relationships form the foundation for a child’s early development and intervention that supports these relationships can enhance children’s development.

“Recent research has pointed to the efficacy of making relationship-focused intervention the focus of early intervention efforts” (Kelly, 1999, p. 5).

Rather than only focusing on the young child, relationship-based practitioners use strategies that support parents in their relationships with their child as the vehicle for intervention. Relationships are being viewed both as “organizers of development and as the basis for all intervention” (Weston, et al, 1997, p.5). For example, it is clear that language is a social tool. A child can best learn language with those with whom he or she spends the most amount of time, those with whom the young child has the strongest social and emotional bond and reasons for communicating. In this example, services should support parents in their efforts to enhance their child’s language acquisition and use. To support a child’s development, early intervention should focus on supporting parent’s competence and confidence to increase the child’s learning and participation in daily life (Bruder & Dunst, 2000).

“Society’s commitment to ensuring the healthy development of every child begins with the parent-child relationship, and requires that the broader institutions affecting the family stand alongside parents in their efforts to ensure the well-being of young children” (Thompson, 2001, p. 32).

### **Parent -Practitioner Relationships**

“The success of all interventions will rest on the quality of provider-family relationships, even when the relationship itself is not the focus of the intervention” (Kalmanson & Seligman, 1992, p. 48).

Recognizing that children grow and develop in the context of their ongoing relationships with their parents and families, the best way to support young children is to support the parent-child relationship. *From Neurons to Neighborhoods* found that the ultimate impact of intervention is dependent not only on the expertise of practitioners, but also on

“..the quality and continuity of the personal relationship established between the service provider and the family that is being served” (National Research Council, 2000, p. 365).

Federal legislation has shown a commitment to the importance of relationships. The Individuals with Disabilities Act (IDEA) has articulated two clear needs for early intervention: 1) to enhance the development of infants and toddlers with disabilities and to minimize their potential for developmental delay; and 2) to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities (IDEA, 1997). Because we know that young children grow and learn in context of their relationships with their most primary and trusted caregivers, building relationships with parents helps us to accomplish both goals. The relationship between a parent and service provider has been shown to be a potential predictor of the success of intervention (Kelly, 1999). An approach to intervention that is both family-centered and strengths-based helps families feel more confident and comfortable in supporting their children’s development (Wilcox, 2001).

The importance of parent-practitioner relationships extends to other family members as well. Brothers, sisters, and other family members often play an integral role in the life of the child. In *Is Being a Good SLP Good Enough?*, Nancy Keenan-Rich wrote about her transformation to using a relationship-based approach,

“I became attuned to family strengths and increasingly discovered that different family members could play a part in intervention. There have been many older sisters who loved participating and playing teacher” (2004).

A child’s relationships with consistent caregivers in addition to the nuclear family are also important. Secondary only to the immediate family, many young children’s development unfolds in the context of child care, the setting in which many children, “first learn to interact with other children on a regular basis, establish bonds with adults other than their parents, receive or fail to receive important inputs for early learning and language development, and experience their initial encounter with a school-like environment” (National Research Council, 2000, p. 297).

Because of the significant influence of child care providers and the child care environment, early intervention practitioners need to establish relationships with child care staff that have the potential to influence children’s learning and development. A focus on relationships is harmonious with the family-centered perspective that regards parents as full partners in all aspects

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of service delivery. Parents and practitioners interact during many early intervention processes including first contacts, evaluation, assessment, determining outcomes, planning services, implementing the plan of action, and planning transition from Part C services. Effective, trusting relationships among parents and practitioners is important throughout all of these processes. For example, Miller and Hanft (1998) commented on the importance of relationships during the assessment process,

“The single most important factor in ensuring a positive assessment experience is the presence of a strong, collaborative relationship between specialists and family members” (p. 49).

By emphasizing strong relationships with parents and families, practitioners attend not only to *what* they do, but also to *how* they do it. Practitioners can most effectively share their knowledge, perspective, and resources to a family in the context of a trusting relationship. The way that expertise is delivered becomes an essential aspect of the work;

“How the therapist conveys specialized knowledge may well determine whether or not he or she gets a chance to use the rest of this expertise...” (Leiberman & Pawl, 1993, p. 430).

In addition to one’s expertise in child development and training in a specific discipline, practitioners must also master a range of general interpersonal skills needed to build individualized, respectful, responsive, supportive relationships with families. These include the abilities to listen carefully, demonstrate concern and empathy, promote reflection, observe and highlight the parent/child relationship, respond thoughtfully in emotionally intense interactions, and understand, regulate, and use one’s own feelings (Gilkerson & Taylor Ritzler, in press).

### **Practitioner-Practitioner Relationships**

“In the old hierarchical model, the name of the game was “do your job and please the boss.” Now it’s about working and learning with people whose experience, education, gender and professional affiliation all differ. So the age of teams is also the age of diversity” (Seagul & Horne, 1997).

Effective relationships among practitioners have long been recognized as important to early intervention. Without close communication and collaboration, there is a greater risk of fragmentation or duplication of services as well as unmet family needs. A number of key ingredients that support practitioner-practitioner relationships include: building authentic relationships by being direct, honest, and supportive; having consistent, predictable, regularly scheduled meetings for team members to establish and maintain close communication, identify issues to address, express needs, feelings, ideas, and participate in group problem-solving and decision-making; and support from a supportive facilitator (Poulsen & Cole, 1996).

There is an even more urgent need for effective relationships among early interventionists as programs increasingly recognize the benefits of a transdisciplinary approach (McGonigel et al, 1991; Hatton et al, 2002; CT Birth to Three System, 2002). The transdisciplinary approach views children’s development as integrated and interactive and seeks to serve children in the context of their relationships with their family (ERIC, 1989). As more communities provide an option for families to receive supports and services through transdisciplinary teams, relationships among practitioners are paramount. Transdisciplinary team members practice deep levels of interaction as they cross and recross disciplinary boundaries to maximize communication, interaction, and cooperation among team members (ERIC, 1989). Role release and expansion presents many opportunities for practitioners to both extend their own roles and support team members to do the same. Team members commit to learning from one another, sharing the theoretical knowledge, research base, and practice skills of their disciplines. Collaborative assessment, planning, service delivery, evaluation, decision making, problem-solving, and conflict resolution require strong, trusting, committed relationships among the team members. Such relationships are built over time; it is essential that transdisciplinary teams have regularly scheduled meetings to build their capacity to do the work at hand.

### **Supervisor-Practitioner Relationships**

“Working with infants and their families, especially where children have special needs, can be emotionally provocative and challenge long-standing defenses and coping strategies for professionals as well as for parents” (Kalmanson & Seligman, 1992, p. 52).

“The practitioner’s experience in supervision directly affects the interactions he has with the child and family. It is this complex nest of relationships that we care about” (Pawl, in Shahmoon Shanook, Gilkerson, Eggbeer, & Fenichel, 1995, pp. 43-44).

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Programs need to provide a supervisory structure that supports practitioners in their relationship-based work. A supervision relationship should model the kinds of interpersonal interactions that characterize other relationships (McCollum et al, 2001). Work with young children and their families can bring with it a number of potential stressors, e.g. heavy caseloads, difficulty in connecting with a family, challenge of maintaining objectivity, loss of morale from observing examples of potentially harmful parenting (Parlakian, 2001). Thus, it has become accepted that working with infants and their families from a relationship perspective requires ongoing, regular opportunities for reflection (Fenichel, 1992; Bertacchi, 1996; Norman-Murch, 1996, 1999; Gilkerson and Taylor Ritzler, in press).

“Reflection is a time to slow down, to see what can be learned if we take the time to carefully look at and listen to ourselves, and those with whom we work” (Parlakian, 2001, p. 16).

To meet this need for reflection, many programs have adopted the practice of reflective supervision, an approach designed to encourage learning through thoughtful observation of oneself and others (Parlakian, 2001). Reflective supervision forms a cornerstone of supervisory interaction in a relationship-based program (Pilkington & Malinowski, 2002). Reflective supervision involves thoughtful dialogue and active listening. It can be accomplished through individual, group, and/or peer supervision.

“When we grow strong relationships with staff, we are helping them grow strong relationships with families as well” (Parlakian, 2001, p. 13).

### Organizational Support for Relationships

“A relationship-based organization is one in which quality relationships characterized by trust, support, and growth exist among and between staff, parents, and children; these relationships form the foundation for all the work that’s done. Relationships are valued, not as a “touchy feely” nicety, but as a foundation for doing business” (Parlakian, 2001, p.1).

In addition to reflective supervision, organizations need to provide a range of other resources to support a relationship-based approach (Weston et al, 1997; Fenichel, 1992). The organizational structure of the program needs to parallel and model a relationship-based direct service approach. Organizational features such as mission, training, billing systems, program evaluation, personnel policies, supervision, and communication channels should be developed with the intent to support relationship-based practices (McGonigel et al, 1991; Weston et al, 1997; Pilkington & Malinowski, 2002). Administrators need to set a tone that values and supports a deep level of teamwork, communication, and problem-solving. Organizations need to secure funding to support the otherwise non-reimbursed time required for essential functions such as teamwork, planning, training, and supervision.

### Summary

Every relationship has the potential and power to enhance other associated relationships (Gilkerson & Taylor Ritzler, in press; Weston et al, 1997). *Administrative support* can set the tone for the quality of *supervisor-practitioner* relationships. Supervisory relationships can enhance both *practitioner-practitioner* relationships and *practitioner-parent* relationships. And all of these relationships, in turn, strengthen *parent-child* relationships. It is through these essential interrelated relationships that we create a web of support for our young children.

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By Larry Edelman

The idea of sending visitors into families' homes to provide support and services is not new. Home visiting can be traced back to the 1880s in the United States and much earlier in other countries (Gomby, 1993). There are many different kinds of home visiting practiced today. Although various models may appear similar, there are significant differences – in the kinds of families they serve, the program's goals, the qualifications of the visitors, the assumptions made about ways to effect change, and the methods used (Powell, 1998). For example, there are home visiting programs designed to: prevent children being born prematurely; enhance child development; promote health; promote school readiness; prevent child abuse; provide assistance to families living in poverty; and address child welfare issues. Because home visiting is used for so many different purposes in so many different ways to serve so many different kinds of families, it is really a generic term – there is no one standard approach.

Home visiting as a strategy to deliver supports and services to infants and toddlers with disabilities and their families is an urgently important topic. Early intervention services have been provided in families' homes for at least 30 years. According to recent data the home is the most common program setting for children and families served under Part C of the Individuals with Disabilities Act (U.S. DOE, 2002). This might be expected as Part C requires that "To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate" (IDEA, 1997). But even though more than 60% of early intervention services are delivered in families' homes, scant research has been conducted on home visiting services (McWilliam, in press; Margie & Phillips, 1999). Despite the shortage of research, there is widespread belief that delivering early intervention supports and services in families' homes has great potential to positively impact children and their families. Although there is no one "cook book" approach to providing early intervention home visits, there are a number of interrelated approaches that, taken together, can shape our work. The principles and strategies described below come from several sources, including research on home visiting, family support, early intervention, and children's learning and development; recommended practices articulated by professional associations; guidance from IDEA; and theory on how children learn and develop.



## Principles and Strategies for Providing Family-Centered, Home-Based Early Intervention Services

### Recognize that the term "home-based" implies more than just "place"

The term "home visiting" implies more than the mere locations where services take place (Margie & Phillips, 1999). Equally, if not more, important are the goals for intervention, strategies used, how supports are delivered, and who is involved. Home visiting doesn't mean that we simply take what we once did in a clinic, office, or school setting and merely do it in another place. The term "home based early intervention services" implies a unique approach to practice that integrates the cluster of interrelated principles and strategies described throughout this article.

### Respect the family

A family-centered approach means that visitors recognize and respect that:

- Receiving services in one's home is a family's choice; home visitors should not impose things that families do not choose.
- Parents are central and essential participants and team members; home visitors cannot provide support without them.
- Parents have the right and responsibility to make decisions for their young children; home visitors need to support them in making informed choices by sharing their information and experience with them and then honoring parents' rights to determine their own service needs.
- Parents know their children; home visitors need to respect families' observations.
- Each family has unique culture and values; home visitors must honor these – especially when the family's culture and values are different from their own.
- Home visitors are guests in families' homes (and in their lives); home visitors need to be gracious guests.

### Build relationships with parents

How parents and professionals interact with young children, and with each other, contribute as much to the quality of the relationships involved and the developmental outcome as *what* is done in the interaction (Pawl, 1998).

Home visiting means working collaboratively with families in all aspects of planning, delivering, and evaluating services. It means relating to family members as people, not “patients.” It means recognizing all family members, including brothers and sisters, grandparents, and extended family members. It has been suggested that the way in which family support is given is as important as the actual kind of help (Dunst, 1988). A collaborative approach means avoiding trying to take control. It has been suggested that an essential component of effective home visits is developing a shared agreement between the parent and practitioner on the purpose, content, and methods used during the home visit (Powell, 1998). Using the beginning and end of visits to talk with parents about how the visits have been working for them can assist visitors in knowing how to be helpful and supportive.

### Individualize services and supports

It is recommended practice that both child-focused and family-based early intervention practices should be individualized (Wolery, 2000; Trivette and Dunst, 2000). A one-size-fits-all approach doesn't work in early intervention home-based services. Home-based services should be individualized to address the strengths and needs of each child and the unique goals that are central to each family's Individualized Family Service Plan (IFSP). Services should be delivered in ways that are harmonious with each family's priorities, culture, schedule, and lifestyle. The frequency and duration of visits and what happens during those visits should be tailored for each individual child and family. Home-based services don't always happen in a family's home. For some families, at certain times, support might be requested in places other than the home, such as child care centers, grocery stores, cars, and neighborhood parks. [Note: With some modification, the strategies in this article also apply to working with children's primary caregivers in childcare settings.]

### Be flexible

The IFSP provides a framework for supporting young children and their families. Home visitors need to have a strong sense of this framework and should be focused on supporting families in addressing the outcomes that are part of their IFSP's. But because we know that children change all the time, families' priorities change, and “life happens,” home visitors should be flexible and avoid being rigid about what the specific agenda will be during a given home visit. Visitors should “check in” with the family at the beginning of visits to learn how things have been going for the child and family, what significant events may have occurred, what might have changed, and what kind of support the family will find useful at that moment. In this way, home visitors can stay focused on the IFSP, but also be sensitive to changes that might require a thoughtful modification of the plan. Effective intervention starts with the family's

agenda.

### Focus on the child's participation and learning that happens between visits

The reason why home visitors should focus on what happens between visits has to do with how, when, and where young children learn. Children learn throughout the day, at home and in the community, in dozens of everyday routines, activities, and relationships that provide rich, natural learning opportunities. These learning opportunities “are a mix of planned and unplanned, structured and unstructured, and intentional and serendipitous experiences” (Dunst et al, 2001, p. 50). So it makes sense to focus on all of these times rather than only on the actual hour or so of a home visit. Many writers have illuminated the need to focus on what happens between visits by “doing the math” (McWilliam, 2000; Dunst et al, 2001; Dunst & Bruder, 1999; Jung, 2003). A home visitor working with a child independent of the child's caregivers is really only “investing” an hour or so of intervention in a week. But by spending that hour providing primary caregivers with information that will help them to recognize the potential of natural learning opportunities and strategies to add learning and development enhancing qualities to everyday routines and activities, the home visitor is investing in all of the child's waking hours. The wiser investment of time is to support what happens when the visitor is not there. A primary purpose of early intervention is to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities (IDEA Sec. 613).

An effective way to support young children and their families is to spend time talking with families about their everyday routines, activities, and relationships. These periodic conversations help visitors understand what families do every day, what parts of the day they'd like to be different, difficult parts of the day they wish could be easier, the many different family and community-based learning opportunities in their lives, and ways to support children to participate fully in their everyday experiences. Understanding the context of the family's life can help set the course for the kinds of support that is shared with the family. There are many ways to listen to and learn from families about their lives (Woods, 2004; Lindeman & Woods, 2004; McWilliam, 2001; Wilson et al, in press). In summary, “The role of the home visitor needs to reflect the reality that children learn throughout the day, whether planned or otherwise... What happens between home visits is, therefore, critical to children's learning” (McWilliam, in press).

### Provide support to families

McWilliam and Scott (2001) suggest that providing support to families is the most effective way of ensuring that children receiving home-based services receive inter-



They describe three types of support that appear to be basic to early intervention.

**Informational support** centers on what families want to know. This includes information on: the child's condition or disability, child development (including what the child should be doing at this developmental age and what will come next), resources (including services now and in the future), and what to do with the child. McWilliam writes that helping parents know "what to do with the child... actually encompasses the majority of what home visitors do. It also is the real meaning of "therapy" and "special instruction" in home visits. When therapy and special instruction are viewed as informational support, professionals might be more likely to deliver the service in a way that is consistent with how children learn. For practitioners and families who fear that "just providing information" is not what early intervention is about, they can be reassured that it still involves much handling of the child" (in press, p. 11).

**Material support** is an expansion of informational support since it includes assisting families in finding the resources to meet their basic needs. Providing support for families to meet basic needs contributes to overall well being and ability of the family to focus on their other priorities, such as child-level interventions. Research findings support the importance of material support and are "consistent with Maslow's hierarchy of needs; families cannot address abstract needs until more basic needs are met" (McWilliam and Scott, 2001, p. 58).

**Emotional support** can reduce stress, promote well being, and promote positive parent-child interactions (McWilliam and Scott, 2001). Emotional support practices include being responsive to family questions and concerns, maintaining a sense of positiveness about the child and parents, relating to the family as a whole, providing information about the community and about development, and facilitating parent-to-parent connections. These three types of support are described in more detail in the abstract the article, *A support approach to early intervention: A three-part framework* that appears later in this issue.

### **Use a primary service provider model**

Families often report how difficult it is to manage a schedule of multiple visitors each week. In addition to the inconvenience and stress of juggling schedules, when there are multiple visitors there are risks of duplication, gaps, and fragmentation of services and conflicting approaches. In order to address these problems, the primary service pro-

vider (PSP) approach to early intervention has received much support (McWilliam, in press; Hanft, Rush, & Shelden, 2004; Shelden & Rush, 2004). Although models differ, the PSP approach might be generally described as one professional providing supports and services to the family, backed up by a team of other professionals who provide coaching, consultation, and occasional joint visits. Advantages of the PSP approach include enabling visitors to develop strong relationships with children and families and helping ensure that services are efficient. In addition, because the PSP looks at the whole child in context of his or her family and community (rather than focusing narrowly at disciplinary goals), the model keeps intervention focused on functional goals that the family finds meaningful.

### **Reflect on your experiences**

Home visiting can be a very rewarding way to work with young children and their families. But a full schedule of visiting families each week can be difficult and stressful. Reflective practices help home visitors deal with their stress and continually learn how to be effective. Every contact with a family is an opportunity to understand more about children and families, ways to best support them, and about oneself. A reflective approach to practice encourages observation, self-awareness, and insight. Whether alone or with families, colleagues, or supervisors, home visitors should continually reflect on their work. One way is to "debrief" right after visits by thoughtfully considering a range of questions (Pawl & Dombro, 2001). What happened during the visit that went well? What did you do that made you feel supportive and helpful? What was difficult for you? How might you approach things differently next time?

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## Hanen Workshop

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## Family and Child Outcomes for Early Intervention and Early Childhood Special Education February 2005

### Background

The Early Childhood Outcomes (ECO) Center was funded by the Office of Special Education Program to develop an approach for collecting data on child and family outcomes for the Part C early intervention and Part B preschool programs of IDEA (Individuals with Disabilities Education Act). The resulting data are to be used for federal and state accountability purposes and to improve programs. The family and child outcomes in this document are the product of the initial step in developing this approach. The outcomes were developed through a year-long consensus-building process that involved input from and review by numerous stakeholders including federal, state, and local policy-makers and administrators, local providers, family members of children with disabilities, and researchers. The ECO Center tried to incorporate the feedback received into the current version of the outcomes but, not surprisingly, it was not always possible to reflect the diversity of positions on the outcomes. This version of the outcomes represents the ECO Center's current thinking based on the input received. The next step in the process will be to work with OSEP and states on the development of the measurement approach. It is possible that developing the measurement approach may reveal a need for additional refinements in the outcomes.

### Family and Child Outcomes

#### Preface

*Early intervention and early childhood special education support young children with disabilities and their families. For children, the ultimate goal of this support is to enable young children to be active and successful participants during the early childhood years and in the future in a variety of settings – in their homes with their families, in child care, preschool or school programs, and in the community. For families, the ultimate goal is to enable families to provide care for their child and have the resources they need to participate in their own desired family and community activities.*

*An "outcome" is defined as a benefit experienced as a result of services and supports received. Thus, an outcome is neither the receipt of services nor satisfaction with services, but rather what happens as a result of services provided to children and families. The child and family outcomes are interdependent in that positive outcomes experienced by the family serve to promote the child outcomes and outcomes achieved by the child benefit the family.*

*As outcomes in an accountability framework, these statements should be taken as desirable accomplishments of the system. It is understood that a service system cannot guarantee the achievement of any outcome involving families or children. The achievement of an outcome is the result of a variety of factors, only one of which is early intervention or preschool special education. Even in the best system, it is likely that not all families or children will achieve all of the desired outcomes. Nevertheless, early intervention and early childhood special education should strive to achieve the outcomes for all the families and children they serve.*

#### Family Outcomes

1. Families understand their children's strengths, abilities and special needs.
2. Families know their rights and effectively communicate their children's needs.
3. Families help their children develop and learn.
4. Families feel they have adequate social support.
5. Families are able to access services and activities that are available to all families in their communities.

Based on input from the consensus-building process, it was concluded that all five family outcomes apply to early intervention and outcomes 1 and 2 and possibly 3 apply to early childhood special education as it is currently being delivered.

## Child Outcomes

1. Children have positive social relationships.
2. Children acquire and use knowledge and skills.
3. Children take appropriate action to meet their needs.

### **Additional Information about the Family and Child Outcomes**

The family and child outcomes were written to be simple and straightforward statements but the few words of each outcome encompass important concepts that might not be readily apparent. Additional information is presented to further clarify the intended meaning of the each outcome.

## Family Outcomes

A brief explanation is presented for each family outcome. Examples of the kinds of knowledge or behaviors referred to in the outcome are included to illustrate what is meant by the outcome. The examples are not meant to represent all possible knowledge and behaviors that could be considered part of the outcome.

### **1. Families understand their children's strengths, abilities and special needs**

To promote development and speak effectively on behalf of their children, all parents must recognize their children's unique features that will influence developmental progress. Parents of children with special needs face unique challenges in learning about their child's strengths, abilities, learning style, and temperament, since children with special needs often display atypical patterns of growth and development. They often have special risk factors, health problems, conditions, or diagnoses that are unique and require parents to learn new information about such diverse topics as genetics, medications, surgeries, seizures, need for adaptive equipment, or special learning needs (e.g., use of augmentative communication devices, signing or behavior management techniques). Early intervention and early childhood special education professionals can provide information for families and can help families learn new ways to access this information themselves. This information allows parents to better support their children's growth and development and to represent their children's needs more effectively in planning interventions. Families who understand their children's strengths, abilities and special needs, for example:

- Know expectations for typical development at different ages and stages
- Are aware of how their child with or at-risk for a disability is developing, and what might be the next developmental abilities that could be encouraged
- Understand their child's learning style and preferences
- Are able to observe their child's behavior and notice whether changes occur as a result of services, medication, changes in parenting, or alterations in the home environment
- Know about the special risk factors, conditions, or disability their child might have
- Know about recommended interventions and practices related to their child's special risk factors, conditions, or disability
- Know how to access information about child development or their child's special needs through resources such as other parents, reading materials, professionals, or the Internet

### **2. Families know their rights and effectively communicate their children's needs**

Federal legislation makes it clear that parents of children with disabilities have a set of rights with regard to assent and access to services. All families must be given the opportunity to participate in decisions regarding their child's eligibility for services, the goals to be addressed, and the services provided. Families are to be partners in the design and delivery of intervention and need knowledge and skills to fully participate in the process. Families who know their rights and effectively communicate their children's needs, for example:

- Know their rights and responsibilities related to service provision
- Know where to go for services and other supports in their community
- Know about different service options, and are familiar with the types of services offered by different providers
- Feel comfortable talking with professionals or asking questions
- Know how to use a variety of sources of information (e.g., local parent organizations, the Internet) to find out about rights and services
- Are able to participate as full partners in team meetings to plan goals and services
- Communicate the need for services they feel are important
- Know what to do if they feel that needed services are not being provided.

### **3. Families help their children learn and develop**

A caring, warm relationship between a parent and the child is the foundation for all subsequent development. Families who help their children learn and develop provide for and interact with their children in a variety of positive ways that will promote the development of the child. The family environment is the most influential factor in shaping children's development and learning in the early years. Family environment encompasses the ways parents talk with, teach and discipline their children; the physical environment of the home, the overall tone of family interactions, and the types of out-of-home experiences that parents provide for their children. Families create family environments in many different ways, depending on the culture, traditions, and values held by the family. Professionals can support families in acquiring the knowledge to parent effectively and in putting that knowledge to everyday use. Families who help their children learn and develop, for example:

- Provide a safe, nurturing, and stimulating environment for their child
- Know and use styles of effective parenting
- Help the child participate in family routines and activities
- Feel confident in their parenting skills
- Use special techniques that might be effective in enhancing learning or managing special behavior problems
- Modify the home environment or routines to reflect their child's learning style or needs for adaptive environments
- Know about and help their child use special adaptive equipment
- Know how to access and evaluate the validity of recommendations for dealing with particular learning or behavior challenges

### **4. Families feel they have adequate social support**

Families of children with special needs sometimes feel alone in dealing with the fact that they have a child with a delay or disability. Research has documented the important role of social support in helping individuals cope with stressful or challenging circumstances. Support can come from both formal (e.g., professionals, agencies) and informal (e.g., relatives and neighbors) sources. One clear finding from research is the subjective nature of support. The positive benefits of social support seem to result from the quality of the support as perceived by the person receiving it and not necessarily from the amount of support. What constitutes appropriate support is also influenced by the family's culture and community in which a family lives. By using family-centered help-giving practices, professionals can help families build and use informal support systems. Families who feel they have adequate social support, for example:

- Feel supported in raising their children
- Maintain friendships and make new friends
- Have professionals providing the type and level of support that the family in partnership with the professionals have deemed appropriate for the family.
- Are able to talk to friends and neighbors about disability-related issues
- Are able to participate in desired neighborhood and recreational activities, family functions, and other activities with spouse or friends

- Meet and get to know other families of children with disabilities
- Have neighbors, friends, or family who can provide help (e.g., babysitting)

## **5. Families are able to access services and activities that are available to all families in their community**

Most families need and have access to a wide range of community resources, services, programs, and activities. These resources could include the medical services (e.g., doctors, dentists), child care, religious institutions, libraries, recreational centers, and, for older children, programs such as sports or scouting. Families of children with disabilities often experience challenges in accessing community resources, especially those that seem responsive to their needs and those of their children. The community resources actually used depend on the age of the child, the child's needs, the family's desire to participate in those activities, and what is available in the community in which they live. Families vary considerably in the extent to which they want or need community resources. Professionals can assist families in understanding and accessing the services and activities available in their communities. In communities where these services exist, families who know how to access desired services and activities, for example:

- Have quality childcare that is responsive to the unique needs, strengths, and abilities of the children so that parents can work
- Have opportunities for their children to have inclusive experiences with children who do not have disabilities
- Have a physician and dentist who can provide care that is sensitive and responsive to their child's special needs
- Have acceptable and trustworthy respite care services when informal care is not available
- Are able to participate in religious, recreational or educational activities and programs with families with typically developing children
- Participate in parent organizations or support groups relevant to their child's disability and their family's style and priorities

## **Child Outcomes**

The child outcomes are based on the assumption that children of different ages demonstrate these outcomes in different ways. A second assumption is that there are many pathways to competence and that some children will need special supports or accommodations. The following presents a brief explanation of the outcome and a few selected examples of the behavior or skills that are part of achieving the outcome. The examples are not meant to show all the ways the outcome would be demonstrated across the entire early childhood age span or across the range of abilities and disabilities of children served in early intervention and early childhood special education.

### **1. Children have positive social relationships**

As noted in the discussion of the first family outcome, a caring, warm relationship between a parent and the child is the foundation for all subsequent development. From this foundation, the young child begins to develop a positive sense of self and can begin to build more relationships with other family members and those outside of the family such as peers. Making new friends and learning to get along with others is an important accomplishment of the early childhood years. Children develop a sense of who they are by having rich and rewarding experiences interacting with adults and peers. They also learn that different rules and norms apply to different everyday settings and that they need to behave accordingly. All children need support from adults in learning how to be successful participants in their social world but some children who face challenges in this area need additional or specialized support. Children who achieve this outcome show a variety of behaviors related to making and maintaining positive social relationships in age-appropriate ways. For example, they:

- Demonstrate attachment with the significant caregivers in their lives.
- Initiate and maintain social interactions.
- Behave in a way that allows them to participate in a variety of settings and situations, for example, on the playground, at dinner, at the grocery store, in child care, etc.

- Demonstrate trust in others.
- Build and maintain relationships with children and adults.
- Regulate their emotions.
- Understand and follow rules.
- Solve social problems.

## **2. Children acquire and use knowledge and skills**

Over the early childhood period, children display tremendous changes in what they know and what they can do. Everyday life can present children with a wide variety of natural learning opportunities that serve to help children acquire progressively more advanced skills. Parents and other adults support children's acquisition of knowledge and skills by providing children with safe, nurturing and stimulating environments in which learning can flourish. Children with special needs can face a variety of challenges related to acquiring knowledge and skills and may need additional supports to realize their potential. The knowledge and skills acquired in the early childhood years, especially those related to communication, pre-literacy and pre-numeracy, provide the foundation for success in kindergarten and the early school years. Children who achieve this outcome show a variety of behaviors related to acquiring and using knowledge and skills across a variety of everyday routines and activities. For example, they:

- Display curiosity and an eagerness for learning.
- Explore their environment.
- Explore and play with people and objects including toys, books and other materials
- Engage in daily learning opportunities through manipulating toys and other objects in an appropriate manner.
- Use vocabulary either through spoken means, sign language, or through augmentative communication devices to communicate in an increasingly complex form.
- Learn new skills and use these skills in play, for example, by completing a puzzle or building a fort.
- Acquire and use the precursor skills that will allow them to begin to learn reading and mathematics in kindergarten.
- Show imagination and creativity in play.

## **3. Children take appropriate action to meet their needs.**

As children develop, they become increasingly more capable of acting on their world. Babies cry to communicate hunger whereas an older child can ask for something to eat. Children have a variety of needs – to eat, sleep, play, move, explore, and communicate to name but a few. With the help of supportive adults, young children become able to address their needs in more sophisticated ways and with increasing independence over the course of the early childhood years. They integrate their developing skills, such as fine motor skills and increasingly complex communication skills, to achieve a goal that is of value to them, such as showing their artwork to an adult and describing what it is or pointing to a toy and asking for it. Children with disabilities may use specialized technology or may need assistance from adults to allow them to meet their needs. Children who take appropriate action to meet their needs show a variety of behaviors related to this outcome. For example, they:

- Use gestures, sounds, words, signs or other means to communicate wants and needs.
- Meet their self care needs (feeding, dressing, toileting, etc.). Their ability to meet self care needs allows them to participate in everyday routines and activities.
- Use objects (for example, forks, sticks, pencils, crayons, clay, scissors, switches, other devices, etc.) as tools in appropriate ways.
- Move from place to place to participate in everyday activities, play, and routines.
- Seek help when necessary to move from place to place.
- Seek help when necessary to assist with basic care or other needs.
- Follow rules related to health and safety.

# Self-Assessment

The self-assessment for this edition of the training times is short answer. You are encouraged to take the assessment online at [www.utsprokids.org](http://www.utsprokids.org). After January 2006, all assessments must be completed online. This assessment will be scored Pass or Fail, based on subjective measures of effort and general understanding of the subject matter. **There will be no make up assessment—please make sure you submit your assessment by the December 15th deadline.**

**If you must submit a paper assessment, the following information must be completed.** Assessment scores are emailed back. (All providers, by your provider agreement are required to have a working email address (see insert below). **Please print legibly.**

Name: \_\_\_\_\_ Email address: \_\_\_\_\_

Your answer should be of sufficient length to fully answer the question, **but please do not write an essay.** You may attach a separate page with your answers.

1. Explain why child/family outcomes should not be discipline specific. \_\_\_\_\_

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2. Explain what it means to be reflective with families. \_\_\_\_\_

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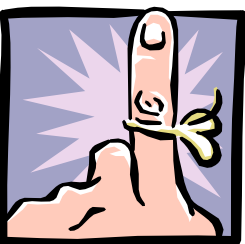
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## Provider Agreement Reminder

In order to become a First Steps provider, you signed a CRO Provider Agreement. (For reference, providers can obtain a copy of the Provider Agreement at the EIKIDS web page. [www.eikids.com](http://www.eikids.com). Click Service Matrix from the menu on the left side, on the next page click the word documents, and on the next page you will see CRO Agreement. This will allow you to download a copy, if you have misplaced your original.) Under Provider responsibilities, #21 Maintain business email, and dedicated phone and fax lines. Email, phones and fax machines used to convey child/family information must be secure to protect the privacy of the child/family. For independent providers, this precludes the use of a single family email address and/or a single family phone line, with out a specific, secured, voice mail box for your First Steps business. Fax machines must also be secure. It is improper and a breach of confidentiality to use a spouse's work fax. A home fax machine should be located in a home office, so that family members do not have access to confidential information. Fax machines must be able to accept facsimiles during regular business hours, whether you are in your home office or out on appointments. Providers and Service Coordinators who violate this responsibility of their Provider Agreement should be reported to their LPCC and state consultant.

UTS Programmatic Training  
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## UTS Connect Office Moves To ProKids

On October 1, 2005, UTS Connect moves to the UTS Programmatic Training office at ProKids. This move will join registration functions with programmatic training. Providers will be able to access one source for course information and registration.

The move will necessitate changes in the UTS Connect phone and fax numbers and the email address. Please take a moment to note the new contact information.

UTS Connect Phone (317) 472-5602 or toll free 877- 434-6085

UTS Connect Fax (317) 205-2592

UTS Connect Email: [training@utsprokids.org](mailto:training@utsprokids.org)

Also in October, UTS Connect will begin on-line registration for all UTS trainings. Providers can link from the Early Childhood Calendar or the UTS ProKids web page. You will need the email address that you used for provider enrollment (the one listed on your matrix) and a password. Providers will be able to view all UTS attended trainings and print these for credentialing purposes. You may also edit your information and password at any time. The on-site registration site will accept VISA, Master Card, purchase orders or personal checks. Once you register for a course, you will receive an email confirmation. Until the site is fully operational and for those who just can't make the cyber jump, paper registrations may still be used, a revised registration form can be found on page 3, at the UTS ProKids web page and from the Early Childhood Meeting Place calendar. Please destroy all old registration forms.

Annual provider training fees are not due until December 2005. At that time, you will be able to register for all mandatory meetings and your quarterly *Training Times*. The fee will remain at \$60.

Visit the newly revised website at [www.utsprokids.org](http://www.utsprokids.org)