KIT
"Keeping In Touch"
June 2010

A Publication of the Army Educational & Developmental Intervention Services CSPD

Resource Article

There have been great advances in augmentative and alternative communication (AAC) supports and services since the early 1980's, yet the inclusion of these advances has not carried over to early intervention. In the KIT article this month "Augmentative Communication and Early Intervention Myths and Realities," the authors Romski and Sevcik explore myths that may be contributing to the slowed advancement of AAC in early intervention.

The developmental power of communication is important for children's overall development as it allows children to express their desires, emotions and share their knowledge and understanding. While not all children with disabilities experience difficulty with communication, many that do might benefit from intervention involving the use of manual signs, communication boards, computerized devices, which are all types of AAC. AAC can be unaided (i.e., gestures, facial expressions, signs or other methods not requiring any external support) or aided (i.e., communication boards, picture systems, computerized devices or other methods requiring some type of external support). AAC in early intervention can play four different roles depending upon the individual needs of the child. Romski and Sevcik define these roles as 1) augmenting existing natural speech, 2) providing a primary output mode for communication, 3) providing an input and an output for language and communication, and 4) serving as a language intervention strategy. Yet, AAC is used infrequently. To help explain why this may be the authors examine six myths about the use of AAC and present arguments to refute the myths.

1. AAC is a "last resort" in speech-language intervention. Initially this was the case; AAC was regarded only as an option after all other approaches had been exhausted. More recent information and research however reinforces that AAC should be employed before communication failure as a means to actually prevent that from happening.

2. AAC hinders or stops further speech development. The evidence does not support this myth, and in fact some studies suggest that AAC helped improve speech skills.

3. Children must have a certain set of skills to be able to benefit from AAC. Excluding AAC because of noncommensurate intellectual performance or prerequisite sensorimotor skills runs the risk of further hindering the child, as his/her cognitive capacity may not be realized without the means to communicate without AAC intervention.

4. Speech-generating AAC devices are only for children with intact cognition. In the past computer devices were reserved for those who could demonstrate the cognitive capacity to activate the device perhaps in part due to the cost factor and belief that computerized devices require certain sophisticated skills to use. At present however both the costs and complexities associated with computerized devices have lessened.

5. Children have to be a certain age to be able to benefit from AAC. Based upon the authors review there is no supporting evidence for children needing to be a certain age to benefit from AAC.

6. There is a representational hierarchy of symbols from objects to written words (traditional orthography). Children's understanding of referents in their familiar settings is not necessarily tied to the traditional progression from real objects, to photographs, to line drawings, to more abstract representations, and then to written words.

These myths are not supported but continue to linger and influence decisions about AAC intervention with young children. The benefits and requirements put forth in the Individuals with Disabilities Education Act (IDEA) for consideration of assistive technology including AAC reinforce these intervention approaches as viable options for very young children with special needs. "The reality is that it is never too early to incorporate AAC into language and communication intervention for the young child with a significant communication disability" Romski & Sevcik 2005 p. 182.

Romski, M. & Sevcik, R. A. (2005). Augmentative communication and early intervention myths and realities. *Infants and Young Children, 18*(3), 174-185.

On the WWW

www.scoe.net/seeds/resources/at/at.html

The web resource this month is from the Supporting Early Education Delivery Systems (SEEDS) Workgroup on Early Education Technology (SWEET). SWEET is a workgroup created in 2005 convened to link California early intervention programs and families with AT resources. SWEET is specifically designed for young children with disabilities and their families and the SEEDS website on AT is created to help providers and families access current information and resources, including training modules on how to use AT with this very young population.

The online training modules include the following 6 module topics:

1. Overview of AT for Young Children
2. AT and Assessment
3. AT and Communication
4. AT and Emergent Literacy for Infants/Toddlers
5. AT at Play
6. AT and Computers

These modules are available online at:
www.scoe.net/seeds/resources/at/trainMods.html

Each of the modules includes a set of PowerPoint slides, handouts, and resources. Each of the modules provide a great mix of practical information.

At the SEEDS website link for "AT for Infants/Toddlers"
www.scoe.net/seeds/resources/at/atInfants.html
there are further resources organized by the following topics:

- Infant References
- Legal References
- Training Links
- Advocacy/Information
- Best Practices
- Assessment
- Resources

KIT readers are encouraged to check out the SEEDS website on AT. It provides a great mix of resources that are specifically organized with the needs of infants and toddlers with disabilities and their families in mind.

What Do the Data Say?

What are situations/issues that providers might consider when evaluating the need for AT for an infant or toddler?

This question was included in the research conducted by Wilcox, Bacon, and Campbell (2001). The researchers surveyed a sample of 967 early intervention providers. Each provider worked with

early intervention and provided support and services to at least three children per week. Given 13 different situations or conditions, the respondents were asked to identify the liklihood that they would list AT on an IFSP.

The 13 condensed response options organized by the total percentage of respondents indicating that they would be "very likely" or "likely" to include AT on the IFSP considering the given condition/situation are included in the table below.

Considerations for AT on IFSPs		
1	The child meets a developmental milestone and needs AT to prodceed	94.0%
2	The child/family want to participate in some activity and can't without the assistance offered by a device	93.9%
3	The AT will promote family-child-sibling interaction	93.4%
4	New AT is avaialble and makes sense for the child	90.8%
5	Other IFSP team members suggest AT for the chid	88.5%
6	Someone on the team finds out new information about AT that may help the child	83.9%
7	The child's parent requests the use of AT	78.3%
8	There is a change in the child's condition, such as detection of a vision, hearing, or motor problem	76.1%
9	Consideration of AT is required as part of the IFSP process	74.3%
10	The child is having difficulty with something he/she wants to do	68.4%
11	There is a change in the parents' expectations for a child	48.6%
12	The IFSP outcomes have not been achieved	45.4%
13	There is a change in where the child spends time during the day	43.7%

Interestingly, for item 9) "consideration of AT is a required part of the IFSP process," only 74.3% of the respondents rated this situation as "very likely" or "likely" for including AT on the IFSP. Yet, in reality IDEA requires the consideration of AT as part of IFSP development. IDEA defines AT very broadly as: *Any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or imporve the functional capabilities of a child with a disability*.

The EDIS Army IFSP includes a separate section on the IFSP for AT to help teams explicitly consider AT in the IFSP development process. AT can also be considered in the IFSP process, for example as part of the description of present levels of development if the child is using AT, as part of family resources, or as part of transition planning. While AT may be needed to help a child achieve a particular outcome AT is not itself an outcome. Further guidance on including AT in the EDIS IFSP process is included in the IFSP-PD Linking Intervention Processes Handbook (p. 65).

Wilcox, M., Bacon, C., and Campbell, P (2004). National Survey of Parents and Providers Using AT in Early Intervention, *Research Brief Volume 1, Number 3.* Tots n Tech Research Institute. Retrieved April 2010 from http://tnt.asu.edu/research/briefs

Consultation Corner

From March through July 2010 the consultation corner topic is:

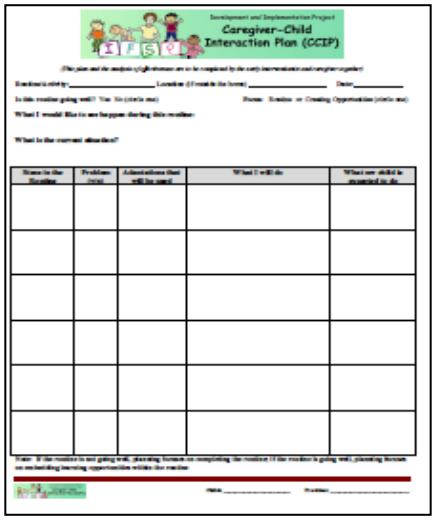
Assistive Technology in Early Intervention

When should AT be used as an intervention with infants and young children?

Previously, we reviewed three tools (the Assessment of Caregiver Activities and Routines, the Intervention Decision-Making Chart, and the Adaptations/AT Planning & Brainstorming form) that have be74.3en developed to help collect information needed for assessment and use of adaptation/AT interventions. An additional tool to use for deciding the type of adaptation/AT intervention that will be needed by the child is the Caregiver-Child Interaction Plan (CCIP). The CCIP and an example of a CCIP can be viewed at the following website:

http://jeffline.jefferson.edu/cfsrp/pbs.html.

Caregiver-Child Interaction Plan & Resource Guide



Providers can use the CCIP to guide and monitor intervention strategies. It is used to develop a written plan for how adaptation/AT interventions will be embedded into families' activities and routines. Having a written plan helps the caregiver and provider know what to do and when to provide opportunities for AT use. The first step in the CCIP is to identify individual steps in a particular activity/routine. Next, determine if any of these steps are a problem. If the step is identified as being a problem, determine whether an adaptation/AT intervention would be helpful. Finally, decide what the caregiver will do and what is expected from the child. By going through the steps of an activity/routine, the caregiver and provider will be able to determine where the problems are occurring during the routine and come up with multiple types of AT to help the child participate in the activity/routine. Once the CCIP has been created, the family should implement the changes to the activity/routine to figure out which options will work best in which situations.

A CCIP Resource Guide was created to assist early providers in creating CCIPs with their families. The guide is divided into 12 activities and routines that many families use each day. It contains examples of CCIPs that can be used as starting points in creating families' personal CCIPs. Each CCIP contains a list of possible steps that may occur during a routine. The examples can be used to help families brainstorm the steps that occur in their own routines. The CCIP Resource Guide can be viewed at this website: http://jeffline.jefferson.edu/cfsrp/pbs.html.

How can we go about making adjustments to AT being used or tried?

Over the course of time, children's and families' needs may change, requiring the use of different types of AT. Each of the aforementioned planning tools (Assessment of Caregiver Activities and Routines; Intervention Decision-Making Chart; Adaptations/AT Planning & Brainstorming form; and Caregiver-Child Interaction Plan) can be revisited to modify intervention strategies for the child and family. For instance, if the identified activity or routine is going well after the intervention has been implemented, the provider/caregiver may decide to use that activity/routine as a way to provide learning opportunities for building functional skills. On the other hand, if the child continues to have difficulty participating in the activity/routine, the provider/caregiver can focus on using new AT to improve the activity/routine.

Provided below are scenarios that could occur during the assessment process and the steps to take if they do occur:

The AT intervention helped make the activity/routine successful; the AT will now be used in other activities/routines.

- The parent/provider can use this intervention to embed practice and learning opportunities for functional skills into other activities/routines. The caregiver/provider can collaboratively create a planning web to illustrate the number of learning opportunities that will be embedded into activities/routines. The activities/routines are numbered in the order in which additional learning opportunities will be added, whereby number 1 indicates the first activity/routine in which the adaptation/AT will be generalized. Webs may include all the various activities/routines in which a child/family participates.
  i. In contrast to the CCIP, the same skill is embedded across multiple activities and routines — not all at once but in a planned

sequence identified by the provider and caregiver together.

ii. In addition to the planning web, the caregiver/provider can make a detailed plan for how the embedding will occur in each activity/routine using the learning opportunities form. This form includes the same information as the web with the exception of the date in which learning opportunities were added to each of the planned routines and a more detailed description of what will happen during the activity/routine.

iii. Blank versions of the web and the plan mentioned above can be found at this website: http://jeffline.jefferson.edu/cfsrp/pbs.html.

- The parent/provider can use this activity/routine to embed additional learning opportunities for the child. Adding an AT intervention to a successful activity/routine can provide opportunities for the child to learn a new skill.

The AT intervention was tried but it did not make the activity/routine successful.

- The parent/provider can revisit the Adaptation/AT Planning and Brainstorming form and try out a different adaptation/AT. A more intrusive strategy may be needed. For example if the environmental modification of putting bedrails on a child's bed did not stop her from climbing out after being tucked in, the family could try adapting their schedule by adjusting the child's bedtime to 8:30pm instead of 8:00pm.

AT is generally a trial and error process. Here are three important things to remember during this process:

- A child may need to try out more than one device or adaptation before it works. It is not the specific device that is important — in other words, it doesn't matter if the child can use the BigMac voice output or a picture communication board — what matters is that the child is able to communicate across situations.
- A child may need to learn to use the device before decisions can be made about its usefulness or feasibility. Just giving the child a picture board may not be enough for the child to understand and learn how to use it for communication.
- More than one device may be needed for a child to perform a particular skill across all situations. For example, a child may make choices using a picture board, a voice output device, or by selecting objects — each of these forms of communicating choices may be needed for a child to practice across situations.

Continuing Education for KIT Readers

The Comprehensive System of Personnel Development (CSPD) is offering a continuing education opportunity for EDIS KIT readers.

In line with the focus on AT in EI, readers are invited to receive continuing education contact hours for reading the monthly KIT publications (March 2010 through July 2010) and completing a multiple choice exam about the content covered in these KITs.

If you are interested, take the exam online at www.edis.army.mil and upon successful completion, you will receive a certificate of non-discipline specific continuing education contact hours.

Please send your Consultation Corner questions and KIT ideas via email to ediscspe@amedd.army.mil

Educational & Developmental EDIS Intervention Services