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Resource Article

The KIT article this month follows the theme of best practices in early intervention home and community based support and services.

Developing an Individualized Family Service Plan (IFSP) with outcomes that are functional, meaningful, and based on child and family priorities is foundational to the delivery of high quality intervention that is respectful of family dynamics and responsive to family needs. Developing such an IFSP requires an understanding of more than the child's strengths and needs based upon child assessment. It requires an understanding of the child in the context of his/her family and the array of natural interactions and happenings that occur day-to-day. IFSP outcomes derived from child assessment alone tend to be deficit-based domain specific skills that may or may not be contextually relevant to the family's day-to-day life. In contrast, IFSP outcomes identified through a Routines-Based Interview (RBI) are functionally germane to the family's routines and activities and founded on family needs and priorities.

Families are individual and therefore have a unique mix of routines and activities in which they participate or would like to participate. Accordingly, intervention and promotion of children's participation in day-to-day routines and activities must be responsive to each family and their interests. Because a family's day-to-day routines create the context for identifying family concerns and priorities, the RBI is an embedded component of the Army EDIS Individualized Family Service Plan (IFSP) process.

The KIT article this month, "The Routines-Based Interview a Method for Gathering Information and Assessing Needs" by McWilliam, Casey, and Sims, defines the RBI as a means for gathering the rich routines-based information essential for intervention planning. The authors detail the steps of the RBI and highlight essential quality indicators linked to RBI fidelity and model integrity. Findings from a preliminary study on the RBI are also discussed.

Since McWilliam's publication of *Family-Centered Intervention Planning* in 1992 the RBI has developed into a conversational interview with distinct steps and embedded structure. Within the article, the authors describe the rationale for and function of each step of the RBI, define the embedded structure, and provide examples.

The six steps (p. 226) for completing the RBI are:

1) Beginning statements – inquiring about the family's main concerns
2) Routines as the agenda – using the family's day-to-day routines to move the interview along
3) Information from routines – applying an embedded structure (asking about what everyone is doing, what the child is doing, inquiring about the child's engagement, independence, and social relationships) to gather routines-based information
4) Satisfaction with routines – asking about the family's satisfaction with each routine
5) Concerns and priorities – using the interview as the means for family identification of their concerns and priorities
6) Outcome writing – using the family's prioritized list to write functional outcomes

The RBI indicators of quality were defined to ensure model fidelity and integrity. Within this article, the authors define each of the ten quality

indicators and describe frequently made mistakes. These measures of quality provide a helpful backdrop for reviewing RBIs and for identifying opportunities for improvement in conducting RBIs with families and caregivers. The 10 quality indicators (p. 229) are:

1) Active listening
2) In-depth follow-up questions
3) Continuing the conversation
4) Proactive questioning about child development
5) "Smart questions"
6) Nonverbal behaviors
7) Social milieu of routines
8) Seeking evaluative and interpretive options
9) Managing the conversation
10) Empathizing

The results of a preliminary study on the efficacy of RBI are also included in this article. The study included 16 families that were randomly assigned to an RBI or non-RBI group. Half of the families received an RBI as part of their IFSP development process and the other half went about IFSP development in the traditional manner. The results of the study showed that families were more satisfied with the IFSP development process when the RBI was included. Inclusion of the RBI also produced more and more functional outcomes. While further study on the efficacy of the RBI is needed, practitioner feedback on the usefulness of the RBI continues to grow.

McWilliam, R. A., Casey, A. M., Sims, J. (2009). The routines-based interview a method for gathering information and assessing needs. *Infants and Young Children, 22*(3), 224-233.

On the WWW

Last month's KIT highlighted Military One Source (www.militaryonesource.com) as the WWW resource. This month it is Military Home Front (www.militaryhomefront.dod.mil).

Both resources are operated by the Department of Defense (DoD) and have a focus on military members, spouses, and families. Similar to Military One Source, Military Home Front includes a wealth of resources and information for service members, families and those who serve and support troops and families. Military Home Front is the official website for Department of Defense Military Community and Family Policy (MC&FP) program information, policy and guidance. This makes it the one stop link for up to date policy letters, instructions, legislation and other references. It is also the reliable source of information on DoD programs for service members and their families. To help you stay informed you might be interested in subscribing to the eNewsletters.

The "Military Installations" link is a valuable resource for families moving to a new assignment. It is also great for early intervention service providers helping families with the transition process. Use the link to locate specific services or to get a sense of the mix of services available.

www.militaryhomefront.dod.mil

What Do the Data Say?

How many children receive non-IDEA tracking service?

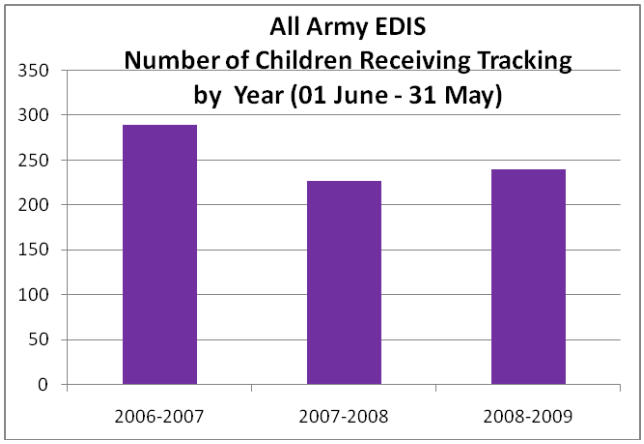
Tracking is a "safety net" option for children who do not meet the eligibility criteria for early intervention service, but there are concerns suggesting the need for a periodic review of the child's developmental progress. Children eligible for early intervention services may also be tracked if the family prefers this option. Because children being tracked are not officially eligible for early intervention services, tracking is a non-IDEA service. The MEDCOM 40-53 directs that tracking should not occur more than once every two months unless the family initiates the contact. Tracking is a great means for keeping an eye on a child's developmental progress when there are mild concerns, such as a child demonstrating borderline skills.

To answer this month's KIT question we present SNPMIS data identifying the number of children receiving tracking per year (01 June – 31 May) over a three-year period. These data were analyzed for all Army EDIS programs and then reduced by EDIS programs in the continental

United States (CONUS) and those outside of the continental United States (OCONUS).

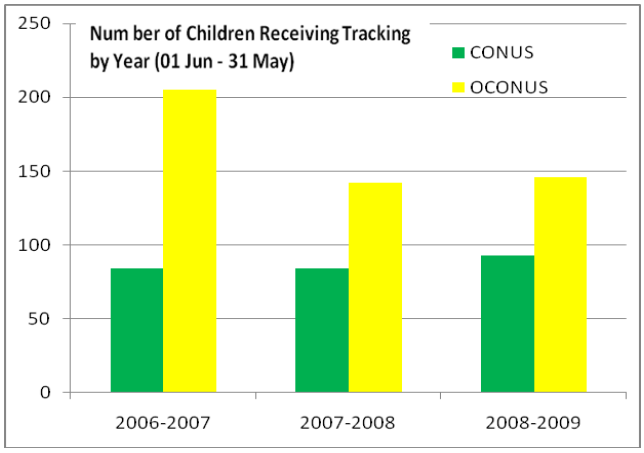
Table 1 below illustrates the number of children receiving tracking for all Army EDIS programs for the past three years. From 01 June 2008 – 31 May 2009, Army EDIS provided tracking services to 239 children. During this same 12 month period in 2007/2008 and 2006/2007 there were 226 and 289 children respectively that received tracking.

Table 1



Over the past three years, the OCONUS programs tracked significantly more children than CONUS programs. Table 2 below compares the numbers of children tracked by CONUS and OCONUS Army EDIS programs.

Table 2



As you recall last month in the June KIT "What Do the Data Say" question, we examined the number of children served in EDIS and saw that OCONUS programs 'served' more children. This may be a contributing factor to the increased number of children receiving tracking in OCONUS programs.

Another possibility may be that there are more children overseas with borderline delays that do not meet eligibility criteria, but benefit from "safety net" support.

Tracking is a beneficial service to offer when a child does not meet early intervention eligibility criteria but there are questions or concerns about a child's developmental progress. Programs are encouraged to continue offering tracking as needed.

Consultation Corner

From March through July 2009 the consultation corner topic is:

Best Practices in Early Intervention Home/Community Based Support and Services

Lee Ann Jung, PhD from the University of Kentucky is the consultation corner specialist sharing her knowledge and expertise on providing early intervention in home and community settings.

[Engaging Families]

What can I do if the child is asleep when I arrive (and I'm concerned that the child sleeps during the day and is up all night)? What can I do if the parent gossips about other families while I'm there? What can I do to help engage the parent during the visit? In a center setting the staff introduce me to the children as "child's special teacher" and expect me to work with that child while I'm there.

If on home visits we only needed to know which interventions work for which skills, our job would be a piece of cake. But we have to figure out how to use children's natural learning opportunities as a source of this intervention, and we need to know how to connect with families in a way that supports their ability to use the intervention ideas. In this final column on home visiting I address several specific

challenges we may encounter as we engage with families.

What can I do if the child is asleep when I arrive (and I'm concerned that the child sleeps during the day and is up all night)?

If their parents are lucky, young children sleep sometimes during the day. Often daytime sleeping is a predictable nap time, but every now and again a child's nap may inconveniently overlap with a scheduled home visit. Or is this inconvenient? Well, that depends on what needs to be accomplished on that home visit. Sometimes families have questions about how to implement an intervention, and it is possible that observing the home visitor doing the intervention is exactly the type of support that the family needs. Or the home visitor may need to observe the child in an activity in order to assess or design an intervention. In either of these cases, yes, the child's being asleep can cause a bit of a kink in the home visit.

Many times, though, what needs to be accomplished during the home visit can occur without the child. Caregivers may need to talk about an issue their family is experiencing. Or they may need to talk about how an intervention has been going and get more information or ideas. In these situations, the child's being asleep can be great! I've had some of the most productive home visits when a child was napping. With the child asleep, the caregiver and provider have a unique chance to devote complete attention to their discussion and may have conversations they never would have otherwise had. Besides, if we are truly providing routines-based intervention, there will be many routines we support that we will *never* see. Support for intervention in routines, especially for those we don't see, involves conversations between adults much more than interaction between provider and child.

The other part of this question has to do with a child's sleeping schedule. The provider may be concerned that a child sleeps too late or too much of the day. One accompanying question we can ask is if this is also concerning to the family. If this is a concern to the family, then by all means we should discuss the issue and determine what type of support is needed. Having a child on a different schedule than what works for the family can be a terribly stressful problem. On the other hand, if the child's late-to-bed, late-to-rise schedule is working for the family, then we have to consider if this really is a concern. Is the child getting sufficient sleep for his or her age? Is the child on a sleeping schedule that ensures he or she is not awake when the family would like to be asleep? If so, then this is a non-issue and we can let it go.

What can I do if the parent gossips about other families while I'm there?

One of the benefits of being in a small town, or on a military base, or in another type of small community where everyone knows everyone is that there is a great deal of support. Moms have other moms to call and get together with. Families have friends with children who they can do things with. And people share similar experiences that offer them the ability to give each other a unique support. On the other hand, there can be a down side to such a Mayberry community. When everyone knows everyone--everyone is interested in what is going on with everyone! This can lead to gossiping, or talking about others in their absence.

Because of confidentiality requirements, providers have a fairly direct exit from the gossip loop. Wording the exit from the conversation can be awkward, though. What is difficult is to end the conversation without sending any signals of judgment. If a parent asks a provider a question about another family, a provider might respond with little elaboration, "I'm sorry, but I can't answer that. I know that families talk with one another and probably share a lot of information about the things going on in their lives, but our confidentiality requirements keep me from being able to share anything about any families I see. But that also means if anyone ever asks me about your family, that I would never share anything without your permission."

It is a little more difficult to end the conversation when an adult instead of asking a question, offers information. Stopping disclosure without sending messages of judgment is tricky. One possible wording is to interrupt as soon as you realize that disclosure about another family is occurring and say, "Before you say anything else, I should tell you that I'm not comfortable discussing other families. I want to be objective

and positive and supportive with each family I see, so it's probably best that I don't hear anything that could affect that. I really appreciate your understanding." Of course, providers have to find a style of communicating that works for them, but the take home message is to stop the conversation in the least offensive way possible.

In a center-based setting the staff introduce me to the children as "child's special teacher" and expect me to work with that child while I'm there.

Similar to the assumptions parents bring to early intervention, early education and care providers also might assume that intervention time is supposed to be used to directly "work with" a child.

When childcare providers are experiencing challenging behaviors in the class, the issue may not be that they assume that you will remove the child as much as it is they *hope* you remove the child. The best way to deal with this type of expectation is to prevent it by spending time at the beginning of the professional relationship explaining how early intervention works—what the purpose of your visits are and how they might look. Once childcare providers realize that you really are there to help support the child in the childcare activities, they come to see that your support in that way improves the whole day for them, not just the hour or so that you are there.

With childcare there can be a high amount of turnover with staff, and sharing this with only the teachers may not be the most effective, or at least efficient, way of preempting the issue. Meeting with the childcare director before ever scheduling an intervention visit can be a worthwhile investment in the relationship with the entire center. Some people will want to ask questions or maybe even read an article on how this looks, but one of the quickest ways to help others understand how the visits will look is to share a video. One of my favorites is a portion of a video that was produced by Larry Edelman and his colleagues, called "Just Being Kids." There is a segment of that video called "Evan's Story" that shows an interventionist working with a family and then at the childcare center. Showing a video like this one can add tremendously to a meeting with childcare providers—and to a first home visit, for that matter. The video can be purchased at http://www.childdevelopmentmedia.com/home-visiting/80295a.html

Giving information and resources is much easier when handled in the very beginning, before the awkward moment of being directed to a room down the hall. Of course, in gaining the buy-in of early care professionals, changing a diaper or two and wiping off the snack table never hurts, either…

I have thoroughly enjoyed "visiting" the Consultation Corner on home visiting. I hope that the ideas have been useful and spark many thoughtful discussions and ideas as providers continue in the ever-changing scenery of early intervention. Please don't hesitate to write if you have any comments or questions: ljung@uky.edu. Take care!
Lee Ann

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 Early Intervention Home/Community Based Support and Services, readers are invited to receive continuing education contact hours for reading the monthly KIT publications (March – July 2009) and completing a multiple choice exam about the content covered in these KITs.

If you are interested, complete 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 share you KIT ideas and questions via email to EDISCSPD@amedd.army.mil