Educational & Developmental Intervention Services (EDIS) Personnel Development

KIT

Keeping In Touch

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"Partnering With Child Care To Support Children & Families In Early Intervention"

Resource Article

Child care providers have a lot on their plates. For those who care for busy toddlers this is especially true. The pace is fast and steady and there's always something happening. Child care providers must meet the needs of their toddlers as well as the requirements of their program. Diaper's must be changed, food must be provided, opportunities for outdoor play must occur, and playful interactions with all the children in a classroom must be part of the everyday routine.

Even with the myriad of requirements and activities that occur within child care, the quality of the relationships between the caregivers and the toddlers is at the forefront of high quality child care programs. Given the large numbers of young children enrolled in center-based child care program, it behooves us to wonder about how child care providers ,in these settings, meet the emotional needs of these youngsters. Biringen et al. (2012) reported their study on this relationship in their article, Emotional Availability, Attachment, and Intervention in Center-Based Child Care for Infants and Toddlers.

Specifically, the researchers set out to study whether training child care providers in Project Secure Child in Child Care would results in positive outcomes for toddlers as compared to a control group. The provided training is referred to as Emotional Availability (EA) intervention and it consisted of two one-hour informational sessions in a group setting at the centers. During these trainings EA was discussed and linked to attachment. Also included was training on different forms of attachment (i.e., secure, insecure/ avoidant, insecure/resistant, and disorganized). The training included practice components with an EA coach, consisting of three to four visits over a three to four-month time period, reviewing the EA Checklist, which is a checklist that rates providers on four dimensions: 1) Tries not to feel or seem bored; 2) Does not seem overwhelmed and stressed; 3) Hugs and works to sooth other babies if distressed, creating greater peace in the room; 4) Does not ignore babies/toddlers in distress and responds without a delay. The practice component included caregivers watching half-hour videos of their interactions,

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followed by the opportunity to narrate what was seen as well as to note how the interaction could be improved. Additional training was provided through assigned readings and bimonthly face-to-face supervision with a focus on increasing the care providers ability to structure interactions with the children to build EA.

The participants consisted of 57 infant/toddler-provider pairings, with 33 in the intervention group and 24 in the control group. The age of the children varied between 11 and 32 months at the beginning of the study and no known children with disabilities were included or identified in the participating centers. Children were enrolled in child care programs for at least 20 hours per week. The average age of the child care providers was 32 and their advanced education ranged from one to three years of college. Ten child care programs were involved in the intervention group and 10 were in the control group. The control and intervention groups participated in a pre and post intervention assessment using the Emotional Availability Scales, Version 3 (Biringen, Robinson, & Emde, 2000), the Attachment Q-Sort (ASQ; Waters & Deane, 1985) and the Caregiver Interaction Scale (CIS: Arnet, 1989). The first two measures regard the child-adult interactions; the third relates specifically to the adults' actions in the classroom. Observers trained in each of the three measures were used to code the two-hour segments (one-half hour of which was video filmed) of the providers in the classrooms between 9:00 and 11:30 a.m. Two observers were present during the sessions and remained unobtrusive to what was happening in the classroom; 2-3 months elapsed between the first (pre) and second (post) sessions.

Not surprisingly, the intervention group fared better than the control group. Children in the intervention group showed increased EA with caregivers, increased child-caregiver security and increase in overall classroom climate. The children in the control group remained the same or showed some slight decline in the various measures. Also interesting, was that caregivers in the intervention group fared better than those in the control group. Specifically, providers in the control group became less structured and less supportive over the time of the study. Perhaps the lack of emotional connectedness with the children resulted in this finding.

Given the transactional nature of the relationships between children and child care providers, it's understandable that by increasing the EA of the providers an increase in EA in the children would result. This has considerable implications. By increasing our ability to ensure positive emotionally supportive interactions at such a young age, might we be able thwart the development of some negative behaviors in children? Bringen et al. noted that their training focused on increasing EA 'structuring' rather than EA 'sensitivity'. They added, "it may be easier to change the caregiver's ability to structure interactions than caregiver sensitivity to a child" (p. 30). This is an interesting point and one we can perhaps consider further when thinking about the parents with whom we work. It's all about the relationship.

Biringen, Z., Altenhofen, S., Aberle, J., Baker, M., Brosal, A., Bennett, S., Coker, E., Lee, C., Meyer, B., Moorlag, A. & Swaim, R. (2012). Emotional availability, attachment, and intervention in center-based child care for infants and toddlers. *Development and Psychopathology*, 24, 23-34.

What do the data say?

How Do DoD Child Care Programs Rank in Quality?

In 1989, Congress passed the Military Child Care Act. This act was instrumental in the creation of high quality Department of Defense child development centers at military installations across the country. The act did several things. It established a sliding fee scale based upon family income, initiated an accreditation system with regular inspections, established staff training requirements, promoted competitive staff pay rates, and systemized practices to ensure child safety and child abuse prevention. Each branch of service operates its child care systems, but all must follow the mandates set forth in the Military Child Care Act of 1989.

Today the military child development centers operate around the globe and are accredited by the National Academy of Early Childhood Programs, a division of the National Association for the Education of Young Children (NAEYC). In a recent Hechinger report by Butrymowics and Mader (2016), the DoD child care system was acknowledged as "the national gold standard."

In the 2013 nonprofit Child Care Aware of America national survey of state oversight and program standards for child care, the DoD came out on top. The 15 benchmarks in the Child Care Aware survey include system requirements such as evidence of program background checks, established education requirements for program directors (the DoD is the only system requiring a bachelor's degree for directors), minimum education requirements for lead teachers, initial and annual training requirements, inclusion of learning activities to promote school readiness and healthy development, basic health and standards, open and frequent parent communication, staff to child ratios and group sizes that comply with NAEYC accreditation standards, oversight caseloads that do not exceed 50:1, and frequent (4 times a year) inspections with public posting of reports. A total score of 150 is possible.

In the 2013 survey, the average score for all States, including the District of Columbia and the DoD, was 92 or 61%, which equates to an academic grade of "D". Yet, the DoD achieved a score of 130 equaling to a "B", which was the highest grade attained and was the only system reaching that grade. Sadly, no stated earned an "A".

Joining the DoD in top overall ranks, but only achieving a "C", were the following states in rank order: New York (77%), Washington (76%,) North Dakota (75%), Oklahoma (75%), Texas (75%), Wisconsin (73%), Delaware (72%), Illinois (72%), Minnesota (71%), Tennessee (71%) and Indiana (70%). On the other end, the lowest overall ranking states were Idaho (15%), Nebraska (31%), California (34%), Louisiana (38%), Alabama (45%), Maine (51%), Wyoming (53%), South Carolina (53%), Iowa (54%), and Mississippi, Connecticut, and Arkansas all at 55%.

It is comforting to know that the DoD child care systems are high ranking. Yet, it is discouraging that no states received an "A" grade. As we celebrate the high quality of DoD child care systems we must also be diligent to identify and act on opportunities for improvement.

Butrymowicz, S. & Mader, J. (2016). How the military created the best child care system in the nation. The Hechinger Report. Accessed online: http://hechingerreport.org/how-the-military-created-the-best-child-care-system-in-the-nation/

Child Care Aware of America (2013). We Can Do Better: Child Care Aware of America's Ranking of State Child Care Center Regulations and Oversight. Child Care Aware of America, Arlington, VA. Accessed from: http://usa.childcareaware.org/wp-content/uploads/2015/10/wecandobetter_2013_final_april_11_0.pdf

Consultation Corner

From August 2017 through January 2018 we are excited to have **Dr. Weglarz-Ward** as our Consultation Corner expert. During this series Jenna will address a variety of questions that will help us understand more about ***partnering with child care to support children and families in early intervention.***

What factors promote and hinder the collaboration among child care and EI providers?

Strong and positive collaborations among early childhood professionals are essential to positive child and family outcomes (Dinnebeil et al., 2008; Guillen & Winton, 2015; DHHS/DOE, 2015). Friend and Cook (2010) define collaboration as "a style of direct interaction between at least two co-equal parties voluntarily engaged in shared decision making as they work toward a common goal" (p. 7). It is a process that includes shared goals, responsibilities, accountability, and resources (Friend & Cook, 2010). More specifically, DEC (2014) recommends that professionals from multiple disciplines and families systematically share information, knowledge, problem solve, plan, and implement interventions. Although extremely valuable and necessary, professional collaboration is challenging. Not surprisingly, time and compensation are common issues that impede collaboration. However, training, communication, and respect also challenge effective collaboration.

Many professionals understand the concept of collaboration. We've all been on a team of some kind at some point. But being in the same room at the same time, even talking about the same child, is not necessarily effective collaboration. Commonly professionals do not receive formal training in collaboration, therefore it is important to learn and practice collaborative strategies in order to best service children and their families. Dinnebeil, Buysse, Rush, and Eggbeer (2008) describe six steps of collaboration including:

- relationship building,
- gathering information in order to understand the issue or situation,
- joint identification of a goal or outcome, usually defined in measurable or observable terms,
- delineating a course of action,
- implementing the course of action, and
- evaluating the success of the course of action and the collaborative relationship itself.

It is also helpful to understand not only their own discipline in relation to philosophy, service delivery, professional recommendations; but other team member's discipline. Additionally, it is important to understand early intervention and special education principles such as child development, inclusion practices, and federal and state policies and procedures. Finally, it is vital to develop interpersonal skills and take time to learn your other team member's interaction styles and preferences. Although collaboration may now sound complicated, taking the time to identify and reflect on these skills will help to create efficient teams with fewer conflicts.

Definition of Roles

Throughout our research, it became clear that providers were not clear on what each other was supposed to be doing related to collaboration. This uncertainty stemmed often from providers not taking the time to plan out their collaboration process and instead assuming what each other was going to contribute. For example, many child care providers did not know that their role in EI was to use strategies presented during visits throughout their daily routines with that child, so often they did not do anything specific with the children between visits. This was frustrating for EI providers. However, no one necessarily discussed that this was a potential role of the child care provider and could help with that child's outcomes. Taking time to establish each other's roles and expectations in the EI process is vital to reducing frustration. As often child care providers are not explicitly invited

Consultation Corner (continued)

into the EI process, EI providers may have to take the initiative to set up a time to discuss EI with the child care provider. During this time, discuss the aspects presented above including examples of what each provider could do during each visit. Remember, however that both child care and EI providers are equal partners in this team so EI providers should approach these interactions respectfully (see below).

Building Communication Systems

Communication is key in any relationship. For collaboration to be successful team members need to be intentional about their communication. In our study, EI providers tended to overestimate their communication frequency with child care providers. Meaning EI providers felt like they were communicating often and clearly with child care providers but child care providers reported significantly less communication from EI providers. For example, EI providers often reported that they would always leave a contact note after the visit and assumed the child care provider would read the note and better understand the expectations between visits. Child care providers on the other hand reported not even knowing there was a note or did not know that they were supposed to read it. Communication is difficult in child care settings in which the child care provider may be caring for many children at once, changing a diaper, or preparing a meal when the EI provider would like to talk. Additionally, as the child care provider is not specifically on the IFSP team, all communication about that child's services is confidential (including contact notes) and parents must consent to this release of information. Therefore, take time to develop a communication strategy including obtaining permission from parents, setting aside time to talk with each other, and being creative about communication (e.g., email, phone calls).

Professional Respect

Conflicts arising from collaboration can impact personal feelings. For example, when an EI provider thinks they provided clear modelling of a specific intervention strategy then learns that the child care providers did not try it between visits, resentment can develop. Additionally, often child care providers believe that EI providers feel superior to them and do not portray respect to them upon visiting their program. In order to team together, professionals need to get to know each other and demonstrate respect for each other. Do this by taking time to value what each other brings to the table. For example, child care providers are experts of the child's daily routine, preferences, and challenges. EI providers are experts at embedding interventions into daily routines. Combining this expertise provides rich experiences for the child and family. Taking a moment to acknowledge positive experiences may provide a foundation for collaboration.

Collaboration is an interactive relationship in which people pool their collective expertise to achieve mutually agreed upon goals (DEC, 2014; Guillen & Winton, 2015). Taking time to intentionally establish collaboration strategies including foundational skills, communication systems, and respect will create a positive atmosphere and

Dinnebeil, L. A., Buysse, V., Rush, D., & Eggbeer, L. (2008). Skills for effective collaboration. In P. Winton, J. McCollum, & C. Catlett (Eds.), *Effective professionals: Evidence and application in early childhood and intervention* (pp. 227-245). Washington DC: Zero to Three Press.

Division for Early Childhood of the Council for Exceptional Children. (2014). *DEC recommended practices for early intervention/early childhood special education.* Retrieved from http://www.dec-sped.org/recommendedpractices

Friend, M. P., & Cook, L. (2010). *Interactions: Collaboration skills for school professionals*. Boston, MA: Pearson Education.

Guillen, C., & Winton, P. (2015). Teaming and collaboration: Thinking about how as well as what. In Division for Early Childhood (Eds.), *DEC recommended practices: Enhancing services for young children with disabilities and their families* (pp.100-108). Los Angeles, CA: Division for Early Childhood.

Weglarz-Ward, J. M., & Santos, R. M. (2015-2017). *Project Collaborative Care: How Child Care and Early Intervention Providers Support Infants and Toddlers with Disabilities in Child Care.*

On the WWW

The Early Intervention Training Program (EITP) in Illinois has a great two page flyer on "Working in Child Care as an EI Provider".

This flyer is filled with ideas and important considerations for early interventionists partnering with child care providers to support the growth and development of children receiving early intervention services. The recommendations for interactions during visits and throughout intervention are important reminders for early intervention providers.

Check out the document and the embedded resources online.at

https://illinois.edu/blog/files/6039/230963/72908.pdf

Continuing Education for KIT Readers

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

In line with the focus on Partnering With Child Care To Support Children and Families in Early Intervention, readers are invited to receive continuing education contact hours for reading the monthly KIT publications (August—December 2017 and completing a multiple-choice exam about the content covered in these KITs.

KIT readers will receive the exam in January 2018. There is no need to register for the CEUs.

Rather, if you are interested, complete the exam online at www.edis.army.mil

Upon successful completion of the exam, you will receive a certificate of non-discipline specific continuing education contact hours.

KIT Newsletters are available online at **www.edis.army.mil**

Thank you for your continued interest in the KIT.