CHAPTER 8

Support-Based Home Visiting

R. A. McWILLIAM

HOME VISITING IN EARLY INTERVENTION

Working with families of young children with special needs—what this book is about—when the child is younger than 3, is mostly about home visiting. Of course, other settings and events give professionals opportunities to work with families, but, as described below, the home visit is the most prevalent setting. Whereas some other chapters are concerned primarily with individualized family service plan (IFSP) development, this one, like Chapter 7 on the primary-coach approach, is concerned with week-in, week-out, ongoing interactions with families.

Seventy-two percent of children served under Part C of the Individuals with Disabilities Education Act (IDEA) are reported to be receiving services in the home (United States Department of Education, 2003). An astonishingly small literature provides evidence-based guidance about what to do on home visits to children with disabilities and their families. To confuse matters, more than one kind of home-based program for early intervention has been studied, such as those for infants born at low birthweight and prematurely, but not necessarily with disabilities (e.g., Liaw, Meisels, & Brooks-Gunn, 1995). These programs have not been based on the same principles and legislation as "Part C" home visits. Other types of home visits for infants and toddlers are British health visitors for any children (Kendrick et al., 2000), Early Head Start (Love et al., 2005), Nurses for Newborns (e.g., Korfmacher, Kitzman, & Olds, 1998), and programs for families identified as at risk of child abuse (Duggan et al., 2004). Powell (1993) discussed key dimensions to consider

when viewing different home-visiting programs; these include goals, strategy for change ("home visitor–parent relationship . . . *versus* [my emphasis] dissemination of information," p. 26), host agency, content (child-related *versus* "broader ecology of family functioning," p. 26), and intensity. Notably, however, disabilities are not mentioned in Powell's review. A limited amount of research has shown home visits to be effective with families where the mother had the special needs (i.e., depression) but the child did not (e.g., Gelfand, Teti, Seiner, & Jameson, 1996). Home visitors in Part C desperately need guidance, which this chapter provides.

Family Supports and Services: A Backward-Mapping Approach

Home visiting is one of the essential methods for providing family supports. The practices that have evolved from theory, research, and experience fit into a framework tied to accountability outcomes. In a logical system of services, accountability outcomes should be tied to the actual outcomes we desire—what I have termed the moral outcomes. Indeed, it is to be hoped that outcomes for *accountability* should not drive the supports we provide families. The accountability outcomes listed in Table 8.1 are those proposed by the Early Childhood Outcomes Center and those selected by the Office of Special Education Programs (Greenwood, Walker, Bailey, & ECO Center Colleagues, 2005). The moral outcome proposed is improvement in the family's quality of life, defined as the subscales in the Beach Center's Family Quality-of-Life Measure (Park, Turnbull, & Turnbull, 2002) and McWilliam's satisfaction with routines measure (McWilliam, 2005b).

TABLE 8.1. Backward-Mapping Framework for Family Supports and Services

Infrastructure	Practices ←	Content ←	Moral outcome ↔	Accountability outcomes
• Primary service provider (transdisciplinary) • Blended-model service coordinator • Support for primary service provider (other services) • Well-trained personnel • Policies to support natural environments	• Ecomap • Routines-Based Interview • Support-based home visits, including emotional support: • Positiveness • Responsiveness • Orientation to the whole family • Friendliness • Sensitivity	• Family's ecology • Information to family about: • Child development • Resources, including services • Child's disability or condition • What to do with child • Rights	• Other • *Family quality of life* • Family interaction (T) • General resources (T) • Health and safety (T) • Parenting (T) • Satisfaction with routines (M)	• Understand their child's strengths, abilities, and special needs (ECO) • Know their rights and advocate effectively for their children (ECO and OSEP) • Help their child develop and learn (ECO and OSEP) • Have support systems (ECO) • Access desired services, programs, and activities in their community (ECO)

Note. T: Park et al. (2003); M: McWilliam (2005a, 2005b); ECO: Greenwood et al. (2005); OSEP: Office of Special Education Programs, U.S. Department of Education.

If the primary moral outcome is the improvement of families' quality of life, what do we need to attend to on home visits? Two content areas are the family's ecology and informational support. Understanding the family's ecology is essential for (1) letting the family know that home visits are about the whole family, not just the "client" child; and (2) knowing what informal and formal supports are available to the family (Harbin, 2005). Informational support is one of the foundations of support-based home visits (McWilliam & Scott, 2001). Note that one of the types of information provided to families is what to do with the child. This is a highly significant content area, because it is has been the focus of home visits over the years. It is proposed in this model that speech–language services, special instruction, occupational therapy, and physical therapy in the context of home visits in early intervention are, in fact, the provision of informational support to families.

The significance of this proposition is that the clinic-based approach, emphasizing the hands-on work by the professional, consists of a minimal stress on providing information to regular caregivers. In that model, professionals work with the child, sometimes in the belief that they are modeling for the family. Sometimes, such as when the family is not even in the room, not even modeling is the purpose: The purpose is direct treatment. Professionals might say, "Try this during the week." Note that what families are asked to try does not necessarily fit into their routines, because they were demonstrated in the artificial context of the home visit. In fact, it is little better than a strategy shown in a clinic, which is why we have dubbed this a "clinic-based model dumped on the living room floor" (McWilliam, 1998).

If home visits should include providing information to the family, as shown in Table 8.1, what should be the practices or processes to address that content? In this model, those practices are as follows:

1. The ecomap for understanding families' routines.
2. The Routines-Based Interview (McWilliam, 1992, 2005a) (1) to establish a positive relationship with the family, (2) to assess the family's functional needs, and (3) to help the family decide on their priorities for intervention.
3. Emotional support to encourage families.
4. Informational support to increase families' knowledge and skills.

These practices can be implemented in a number of infrastructure arrangements, but what contexts are best for such implementation?

1. A primary service provider model sets the stage for the family to receive a comprehensive set of interventions, rather than the scattershot approach characteristic of a multidisciplinary approach (Hanft, Rush, & Shelden, 2004).
2. A service coordinator model that allows the primary (or a primary) ser-

vice provider to function also as the service coordinator (Bruder & Dunst, 2006).
3. A team of professionals with disparate skill and knowledge sets who, together, back up the primary service provider.
4. A cadre of professionals who are very knowledgeable about child development (normal and abnormal), family functioning, and consultation (including adult education).
5. A method to pay for travel time so services are provided in natural environments.

This logical framework ties together the necessary elements of a system of early intervention. It is preferable to the cobbled-together approach that can be the result of politics, history, payment structures, and misinformation about how children learn and how interventions work.

The FACINATE Context

In providing early intervention, five key elements are linked to form a model called FACINATE: FAmily-Centered Interventions in NATural Environments. The key elements of this model—(1) understanding the family ecology, (2) routines-based assessment, (3) the primary service provider, (4) support-based home visits, and (5) collaborative child care consultation—are shown in Figure 8.1. Most of these key elements have been mentioned already. Collaborative child care consultation is beyond the scope of this chapter, but it should be noted that it consists of inte-

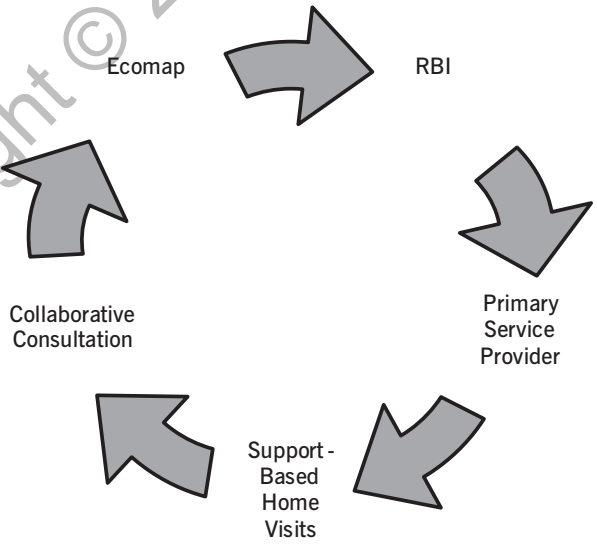

FIGURE 8.1. Key elements of the FACINATE model of early intervention.

grating the consultation into the classroom routines. Children are not pulled out for instruction or therapy. This is consistent with the routines-based approach in home visits.

THE NEED FOR GUIDELINES FOR HOME VISITORS

Because of the relative lack of attention to home-visiting practices in the literature and equally because of my experience in assisting states and programs in implementing support-based home visits, this chapter addresses the need for a set of written guidelines. The guidelines need to address four persistent problems in early intervention. First, the pernicious slide toward overspecialization has advanced a notion that every need requires a service. This can be seen when an early intervention family has a host of specialists making frequent visits. Second, an erroneous belief that more is better, when it comes to the number and intensity of services, has led to the pile-on effect just described. The problem as applied to intensity of any one service is ludicrously seen when a child makes little progress in an area being addressed by a particular service (e.g., a therapy), so the team decides to increase the intensity—as though that were the answer. Third, the failure of professionals to take responsibility for families' difficulty in selecting outcomes has led to pathetically weak IFSPs, where target behaviors are poorly described, criteria for attainment are either absent or nonsensical, and strategies do not match outcomes (Jung & McWilliam, 2005). Fourth, the clinic- or classroom-based model of intervention, dumped on the living room floor, has robbed families of the information they need to provide children with context-relevant developmental help. (See Appendix 8.1, Support-Based Home-Visiting Checklist, at the end of this chapter.)

The Misplaced Clinic-Based Approach

The misplaced clinic-based approach has typically been focused on the toy bag, the ubiquitous crutch of the traditional home visitor. The toy bag implies the family's materials are not good enough, contains toys that are then removed at the end of the home visit, and sets the agenda, in that traditional home visitors went through the toys, one by one. Giving up the toy bag is one of the hardest aspects of this model, so strong is the addiction.

Another characteristic of dumping the clinic-based approach on the living room floor, as it were, is that the home visitor "works with" the child. This implies that the child learns from the visitor, which is misleading for the family. Working with the child directly also leads to complaints about the family's lack of "involvement" during the home visit. Not surprisingly, families who see the professional working with their child might think that this is a good opportunity to catch up on laundry or the soap operas, prompting the professional to lament lack of family

involvement. In general, in the clinic-based approach, the family's primary role is to observe.

There are four problems with this approach:

1. It suggests that child change occurs as a result of home visits, rather than as a result of all the family–child interactions and other adult–child interactions that occur between visits.
2. It oversimplifies the needs that should be addressed in home visits, as though they were simply to provide developmental interventions to the child, which leads to the next problem.
3. It promotes the *got a need, get a service* mentality, requiring a specialist for every need.
4. It falls victim to the *model and pray* notion of how home visits work; that is, that the home visitor models and then prays the family was attending and imitates later.

These problems in early intervention can be addressed with a home visiting framework based on five key principles.

The Five Key Principles You Need to Understand about This Model

1. *It's the family that influences the child, and we can influence the family.* Families have greater influence over children than do home visitors who might see the child for 1 hour a week (McWilliam, 2003).
2. *Children learn throughout the day.* Young children do not learn in clumps of instruction or therapy that requires the processing of multiple rapid-fire inputs (i.e., massed trials; Grisham-Brown, Schuster, Hemmeter, & Collins, 2000).
3. *Early intervention is not about providing weekly lessons.* In addition to the fact that young children learn through distributed trials, they have difficulty transferring from decontextualized settings to regular routines.
4. *All the intervention for the child occurs between visits.* Because of the first three principles above, the function of the home visit needs to shift from direct intervention with the child to support of the caregivers.
5. *It's maximal intervention the child needs, not maximal services.* If the first four principles above are followed, the child's many learning opportunities are maximized and optimized. Regular caregivers' interventions with children are not affected by having more professionals providing more services.

The difference between intervention and service is important for understanding the role of home visits. Intervention is what the child receives, and service is what the caregivers (families and child care providers) receive.

These five principles have been influenced by Bruder's (e.g., 2000) clarifications of family-centered early intervention; Campbell's (1987) description of the integrated-programming team; Dunst's and Trivette's (1988) elaborations of social support, (and with Bruder) learning opportunities, and service coordination (e.g., Dunst, 2001; Dunst & Trivette, 1988; Dunst, Hamby, Trivette, Raab, & Bruder, 2002); McBride's and Peterson's (1997) research on home-visiting practices; Roberts's Rule's, and Innocenti's (e.g., 1998) work on family–professional partnerships; Edelman's (2001) articulation of team models for different disciplines to work together; Hanft et al.'s (2004) primary-coach model; and Woods's and Wetherby's (e.g., 2003) work on embedding intervention in daily routines. The model draws on this body of literature to set the stage for support-based home visits.

Asssumptions

For successful, support-based home visits to occur, four assumptions must be met.

Assumption 1

The first assumption is that we have introduced the FACINATE model early on, so families are not surprised by subsequent approaches we take. When we introduce the model we emphasize that

- We maximize interventions to children.
- More interventions do not come from more services.
- All the intervention occurs between visits.
- The job of professionals is to support regular caregivers. This support is articulated in the following promise we can make to families:

We will inform you.
We will teach you how to teach and do other things with your child.
We will tell you about your child's disability.
We will tell you about resources.
We will teach you about child development.
We will give you access to materials you need.
We will get equipment, including assistive technology, you need to help your child's development.
We will make sure you have access to financial resources that you're entitled to.
We will support you, emotionally.
We will be positive with and about you.
We will be responsive to you.
We will pay attention to your whole family, especially the primary caregiver.
We will be friendly to you.
We will be sensitive to you.

Assumption 2

The second assumption is that we know who is in the family and who important members of the informal, formal, and intermediate support networks are. This is best accomplished by conducting an ecomap.

Assumption 3

The third assumption is that we have a list of functional outcomes or goals, truly decided upon by the family (as opposed to a list decided upon by professionals and approved by the family). Functional outcomes or goals would be based on in-depth assessment of family routines and would be placed into the order of importance to the family.

Assumption 4

The fourth assumption is that the home visitor supports the family with all outcomes or goals, not just some outcomes or goals specific to one discipline. The primary service provider model (e.g., primary coach, transdisciplinary) allows for this type of support, compared to the multidisciplinary or interdisciplinary models, in which home visitors address only those outcomes or goals within their discipline.

The model presented here can be used if one or two of these assumptions are violated, but it is greatly enhanced if they all are followed. Now the early interventionist is ready to provide support-based home visits.

Three Forms of Support

The alternative to the clinic-based model being dumped on the living room floor is support-based home visits (McWilliam, 2000, 2002; McWilliam & Scott, 2001; McWilliam, Snyder, Harbin, Porter, & Munn, 2000). This approach to home visiting revolves around three types of support not unlike Guralnick's (1998, 2001) developmental-systems model for early intervention.

Emotional Support

In a qualitative study of family-centered service delivery in early intervention for children up to age 5 (McWilliam, Tocci, & Harbin, 1998), five key characteristics of emotionally supportive professionals were discovered:

1. *Positiveness*. Being positive to and about both children and family members.
2. *Responsiveness*. Offering to do something when the family expresses a concern and following through in general.

3. *Orientation to the whole family.* Acknowledging family members, especially the primary caregiver, and their needs.
4. *Friendliness.* Treating families like neighbors not clients.
5. *Sensitivity.* Walking in the family's shoes, including not giving them homework they do not want or to be done at inconvenient times.

Other dimensions of emotional support such as empathy and encouragement are important also.

Material Support

Providing material support involves ensuring the family has access to (1) materials and equipment, and (2) financial resources. Materials include necessities such as shelter, clothing, transport, food, and diapers. Being in the home gives the professional the opportunity to see whether these are adequate. If not, they should be the first priority. The home visitor should ensure, directly or indirectly, that the family has access to these materials. Direct support would entail working with agencies and the family. Indirect support would entail passing off this responsibility to another professional, such as a service coordinator, if the home visitor did not have that role.

Equipment consists of the structural supports a child needs to be engaged and independent and have social relationships during routines, such as adaptive seating and communication boards. It can also consist of positioning devices and exercise aids such as wedges, bolsters, therapy balls, corner chairs, and prone standers. Home visitors should help families maintain as normal a home as the family wants, however, by limiting the "abnormal" equipment to what is necessary for successful functioning. Crowding a small living room with exercise equipment for which there is scant evidence of effectiveness might not be in the family's best interest. Whenever possible, home visitors should help families use everyday materials.

Informational Support

When families are asked what more they want from their early intervention providers, they often say information (Sontag & Schacht, 1993). They want information about four things home visitors should be prepared to provide.

1. *Child development.* Families want to know what other children their child's age can do or what comes next, developmentally. Home visitors should be trained to have this information.
2. *Child's disability.* Families want to know about their child's disability or condition. They also sometimes know more about it than does the home visitor. Again, home visitors should know about the most common disabilities or be able to get information about those disabilities they do not know about.

3. *Services and resources.* Families want to know where they can get help and where learning opportunities might exist. The concern about services becomes quite focused at transitions, as the family is preparing to change service providers. Home visitors should know about the resources in their community or where to obtain that information.
4. *What to do with the child.* This is the main part of informational support that early interventionists have traditionally provided, and it will continue to be a very important part. Because the provision of pediatric therapy (occupational therapy [OT], physical therapy [PT], and speech–language pathology [SLP]) and early childhood special education is giving families knowledge and skills (i.e., information) about what they can do in regular routines to help their child, therapy and education in early intervention is actually a form of providing informational support. Framing them as support might help therapists and teachers understand the basic consultative role of their jobs.

Professionals should therefore make home visits with the goals of providing emotional, material, and informational support.

A FRAMEWORK FOR HOME VISITS

A mechanism for helping home visitors focus on support is the Vanderbilt Home Visit Script (VHVS; McWilliam, 2004), shown in Appendix 8.2 at the end of this chapter. It provides home visitors with the agenda they miss when they do not take a toy bag into the home, because the toys in toy-bag-based home visits are the agenda.

Appropriate Use of the Script

The following passage shows the skepticism some leaders in the field have had about the impact of home visits on caregivers' intervening with children intensely enough, without turning them into therapists and teachers:

> Clearly every interaction an infant experiences throughout the day has the potential to influence development. To what extent can weekly home visits and therapy sessions in which professionals interact directly with the child be expected to produce significant benefit? Hanft and Feinberg [1997] have argued that this question cannot be answered without considering child needs and the desires of individual families. Perhaps if the visits are designed to help caregivers structure and support children's usual interactions, more benefit can be expected. However, such approaches, if done inappropriately, may place demands on families to become teachers and therapists and may lead to unintended negative outcomes. Furthermore, the efficacy of home visiting alone as a means of altering developmental pathways for children with disabilities has not been demonstrated. Structuring interventions to impact children's

> usual and day-long interactions will require interventionists to know the contexts in which children spend time; the usual activities, and events in those contexts; the behaviors of adults in those contexts; and children's interest in and reaction to those events, routines, and activities. They will also need to be able to work effectively with families to encourage the application of intervention activities across daily routines. (Bailey, Aytch, Odom, Symons, & Wolery, 1999, pp. 14-15)

The VHVS is designed to help early interventionists work with families like this.

Content

The script comes with directions, guidelines for follow-up questions, and seven lead questions. It is written for home visits by primary service providers (i.e., professionals following a transdisciplinary service delivery model) but it can be adapted for use by multidisciplinary providers. At any time during the interview following this protocol, the early interventionist should provide support to the family, including information.

Follow-Up Prompts for All Script Questions

To ensure home visitors provide emotional support, they are prompted to attend to "the four E's":

- Ears (listen)
- Elicit (ask)
- Empathize
- Encourage

Furthermore, at any time during the interview, they should be prepared to ask the following three questions:

1. Do you need any information to help with this?
2. Should we try to solve this?
3. Would you like me to show you?

The four E's and the offers to provide information, solutions, and demonstration set the tone for the home visit based on emotional and informational support, including information about material support.

Lead Questions

In the VHVS, seven lead questions constitute the structure, but one of these—the third question—is about each outcome. So, in a sense, each outcome carries a lead

question, giving us 12 or more (assuming 6–10 functional, family-centered outcomes) potential lead questions. Many home visits will not last long enough to address all the questions.

1. ***How have things been going?*** This ordinary first question could be the last lead question asked in a single visit, if it generates a lengthy, involved discussion, or it could be simply answered with "OK," "Good," or whatever. It gives the family an opportunity to set the agenda. Although it is a familiar first question, therefore, the answer should sometimes be taken seriously, if the family elaborates on the answer. *Remember, at any point in discussing the answer to this or any other question, the home visitor can offer information, joint problem solving, and demonstration of techniques.*

2. ***Do you have anything new you want to ask me about?*** The idea is not necessarily to set the home visitor up as the expert, so it can be worded, "Do you have anything new you want to talk about?" As with all questions, this one should be paraphrased to suit the people involved. It gives the family a more specific opportunity than the first question to think about new issues, skills, problems, and so on.

3. ***Outcomes in priority order.*** The home visit will go much more smoothly if the goals are functional, preferably based on needs in the family's routines. They are asked in the order of importance the family chose in the development of the IFSP. The question would often be "How have things been going with sitting independently when Raúl is playing with Alejandra?" or whatever the first priority is. It might work just to ask, "How have things been going with sitting?" But, as soon as discussion ensues, it is important to ask about sitting during specific routines, such as, "*When* have you noticed he falls over?" Functionality almost always hinges on the child's functioning in specific situations, because children respond to external stimuli. For example, Raúl's sitting independently in the living room might be hard for him because he keeps turning his head to look at the family dog running around. On the other hand, at night, when he's sitting in his crib, he might do better with the different surface (mattress versus floor) and fewer distractions. Therefore, potential solutions (i.e., interventions) will vary by routine. If the Routines-Based Interview (RBI; McWilliam, 1992, 2005a) was used, there should be 6–10 goals, so it is very likely not all the goals will be covered in a single home visit. From time to time, the home visitor might suggest starting with goals further down the priority list, to make sure none are ignored for weeks on end.

4. ***Is there a time of day that's not going well for you?*** If, miraculously, the discussion of goals does not consume the whole home visit, this question can be helpful for families. It is highly relevant if we believe that helping families increase their satisfaction with routines is a purpose of early intervention.

5. ***How is [family member] doing?*** Because family-centered practices include an orientation to the whole family (McWilliam et al., 1998), it is important to ask about family members other than the target child. Very often, this family member

should be the very person being visited, such as the mother. The question is also pertinent because the child lives in the context of a family.

6. ***Have you had any appointments in the past week? Any coming up?*** Answering these questions can help organize the information the family received at an appointment or organize questions to ask professionals at an upcoming appointment. Keeping up with the information and paperwork related to assessments and check-ups can be challenging for many families of all kinds of backgrounds. It is good not to make assumptions either that the family has all this information under control or that they do not.

7. ***Do you have enough or too much to do with [your child]?*** Although we might have a sense of whether the number of suggestions is more or less than the family wants, it is good to check in with them. If nothing else, asking the question demonstrates the home visitor's sensitivity to the family's desire for amount of advice.

It is unlikely the home visitor will reach all these steps on any home visit, which illustrates a couple of important points. First, there is a lot to do on a support-based home visit, especially considering that the RBI even for children with mild delays will have 6–10 functional outcomes. Because these home visits are very busy, it is difficult to imagine how a reasonable level of support could be achieved without weekly visits. A more dispersed schedule (e.g., twice a month) is likely to suit more narrowly focused visits with fewer outcomes. Second, the VHVS is a reasonable substitute for other agendas, such as toy bags. On first inspection, one might think that seven questions will leave the home visitor and family stranded with nothing to do, but in fact it is a very full agenda. Should home visits be scripted? Note that the agenda consists of prompt questions to ask the family about their priorities. The script encompasses only the lead questions; all the meat of the conversation is in the responses and follow-ups.

What Will Home Visits Look Like?

Home visitors might be afraid home visits will no longer involve interaction between them and the child. It is true that the focus is no longer on that interaction. In some models, the focus is on the interaction between the adult family member (we'll refer to that person as the parent) and the child. Here, that is somewhat of a focus, but the real focus is on the interaction between the home visitor and the parent—on the topic of the interaction of the parent and the child. That is, the home visitor uses appropriate consultative and adult-education strategies to help the parent teach and in other ways intervene with the child.

Home visitors in this model will spend much time talking to the family, but most of the time they will still have their hands on the child. For many home visitors, hands-on contact with children is very important. The three reasons for "handling" the child are (1) to demonstrate intervention strategies; (2) to assess what

the child can do or what might work, before making the suggestion to the family; and (3) to show the parent that the home visitor loves the child. Long after early intervention has ended, families might not remember their home visitor's name and certainly not his or her degrees, but they will remember that he or she loved their child.

The Eight Steps of Modeling: Avoiding the Model-and-Pray Approach

One of the reasons for handling the child is demonstration. In the past, some home visitors who "worked with" the child on home visits would claim they were directly teaching or providing therapy to the child. Those with more understanding about how children learn and how services work would claim they were demonstrating for the parent. Too often, however, the demonstration was clearly not working. This could be seen either by nonengaged parents, who might be talking on the telephone, watching television, or doing laundry during the visit; or, on subsequent visits, parents' revealing they had not imitated what the home visitor had modeled. Such home visitors use the model-and-pray approach. That is, they model and pray that the parent was observing and will spontaneously imitate the model during the week. The antidote to the model-and-pray approach is the eight steps of modeling:

1. Talk to the parent about your suggestion.
2. If the parent appears not to understand, ask if he or she would like to be shown.
3. Tell the parent what you're going to do.
4. Do it.
5. Tell the parent what you did and point out the consequence.
6. Ask the parent if he or she would like to try it.
7. If the answer is "yes," watch the parent trying it; if the answer is "no," leave it alone.
8. If yes, praise the parent and give a limited amount of corrective feedback.

Here is how the eight steps would work when demonstrating to a parent a backward-chaining, full physical prompt to teach the child independent eating with a spoon.

1. "Have you considered standing behind him and help him at the elbow, letting go at the last minute, so he finishes the act of eating with a spoon by himself?" (Talk to the parent about your suggestion.)
2. "I can tell I haven't explained this very well. Would you like me to show you what I'm talking about?" (If the parent appears not to understand, ask if he or she would like to be shown.)

3. "I'm going to stand behind him while he's in the high chair. I'm going to say, 'Time to eat' and then I'm going to hold his elbow, lightly, to guide him to scoop and bring his food to his mouth. When the spoon gets close to his mouth, I'm going to let go of his elbow, so he'll put the spoon in his mouth by himself." (Tell the parent what you're going to do.)
4. "See what I'm doing." (Do it.)
5. "Did you see how I stood behind him? I said, 'Time to eat' and then I held his elbow, lightly, to guide him to scoop and bring his food to his mouth. When the spoon got close to his mouth, I let go of his elbow, so he put the spoon in his mouth by himself." (Tell the parent what you did and point out the consequence.)
6. "Would you like to try teaching him like that?" (Ask the parent if he or she would like to try it.)
7. "You go ahead and do it and I'll watch you and coach you as necessary!" (If the answer is "yes," watch the parent trying it.)
   "If you try it and have any questions next time I'm here, let me know." (If the answer is "no," leave it alone.)
8. "That was excellent! You guided him gently, so he scooped well and brought the spoon to his mouth. Next time, remember to let go of his elbow, so he can do the last part himself." (If yes, praise the parent and give a limited amount of corrective feedback.)

Transdisciplinary Service Delivery

The transdisciplinary approach to service delivery, also known as the primary service provider model or the primary-coach model, is described by Shelden and Rush (Chapter 7, this volume). Because this approach (1) integrates strategies from different disciplines, (2) enhances the relationship of a primary service provider (PSP) and the family, and (3) lowers the burden of participating in professional services for the family (thereby giving them more time to do other things), it is supported in the VHVS. It is consistent with the five key principles listed earlier in this chapter.

Implications for Specialists' Roles

Unfortunately, some therapists fear this model makes them irrelevant. Nothing could be further from the truth. This model requires them to be critical team members and to work with the family to devise appropriate programs of intervention. The difference is that this model focuses on natural caregivers carrying out the interventions throughout the day, thus maximizing the child's learning opportunities. The therapist does not need to be around as often, when the interventions are in the hands of the caregivers. The job of the primary service provider (i.e., the regular home visitor) is to support the family in carrying out those interventions

and to summon the assistance of the therapist when needed. Note that a therapist can be a PSP and summon the assistance of the generalist when needed. Therefore, therapists are needed just as much as ever, but they need to be used differently from the traditional approach of every professional on the team seeing the family frequently.

In addition to the role release required of therapists with this model, therapists need to develop consultative skills as part of "direct therapy." Professional organizations' descriptions of therapy with very young children recognize that "parent education" is a key part of direct therapy, and that is the part that is so critical to the PSP model.

FUNCTIONAL CHILD DOMAINS

As home visitors work with families, they seek to determine needs (see R. A. McWilliam, Chapter 2, this volume) and they provide various types of support. What developmental, behavioral, and ecological framework do they use for assessing and suggesting interventions? Traditionally, they have used domains found in norm-referenced tests and in curricula, such as cognitive, communication, motor, social, and adaptive. A more functional set of domains has been proposed as engagement, independence, and social relationships (see R. A. McWilliam, Chapter 2, this volume).

Engagement

Engagement is the amount of time a child spends interacting competently with the environment (McWilliam & Bailey, 1992). It is closely related to the concept of participation, which the World Health Organization (2007) has emphasized as a criterion for functioning. That is, a person with an impairment is less functionally "handicapped" the more he or she can participate in home, school, work, or community routines. For very young children, the observable and measurable equivalent of participation in routines is engagement.

Historically, engagement was thought of as simply on task or off task (e.g., Risley & Cataldo, 1973). More recent research in early intervention/early childhood special education (ECSE), however, has considered engagement at different levels of sophistication. High-level engagement consists of mastery behaviors, constructive play, and encoded social interactions (e.g., conventionalized language and rule following; de Kruif & McWilliam, 1999; Dunst & McWilliam, 1988). Middle-level engagement consists of neither sophisticated nor low-level participation in routines, but differentiated behavior and focused attention. Low-level engagement consists of undifferentiated behavior (i.e., repetitive actions) and casual attention. Nonengagement can be active, involving crying or being aggressive, or passive, involving needlessly waiting, staring into space, or wandering aimlessly. On home visits,

professionals work with families to determine the amount and sophistication of a child's engagement in each routine and to improve it. The assessment process is best done through a semistructured interview to cover the many ways in which a child could be engaged and to allow the family and the home visitor to ensure they understand each other's concepts of engagement.

Independence

The second new "domain" is independence, which is often concomitant with engagement. That is, children who are more independent in a routine tend to be more engaged in it. To make this functional on home visits, professionals are interested in independence only in everyday routines, not in tests or other decontextualized events. They need to consider cultural norms and individual–family preferences about the extent of a child's independence. Some families believe the role of parents is to do things for children, so they might be less interested in this domain than are other families.

Social Relationships

The third new domain is social relationships, which is the ability to interact successfully with people in the environment. It thus consists of communication and getting along with others. Again, it is not mutually exclusive of engagement. Childen who are competently involved in social relationships will be more engaged than are those who do not have successful social relationships.

If home visitors keep their focus on engagement, independence, and social relationships, they are likely to deal with meaningful functioning and to avoid the pile-on of different services at a high intensity.

TEACHING PARENTS TO TEACH THEIR CHILDREN

The consultative approach is a good and correct one in home visiting, but there are times when parents want to learn specific strategies. The rationale for "training" parents, some key child-instruction strategies, and the use of performance feedback for parent training are discussed.

Rationale and Apology

When families want to know what to do with their children—when that is the type of informational support they are seeking, the home visitor should be able to teach them what to do. Sometimes, other team members are needed to arrive at specific strategies. Parents decide what it is they want their children to do: They are generally able to say what functional behaviors they want to see in their children (e.g.,

nursing, playing back-and-forth games, walking, communicating). But they might not know how to teach these skills to children. One reason might be because the child has difficulty learning or performing the skill. Unlike typically developing children, whose learning, by and large, matches the input from the parents, children with disabilities or difficult temperaments might not be as easy to teach. Even among typically developing children, ease of teaching varies considerably.

A second reason parents might want specific training in what to do with their child is their own difficulty in understanding less structured suggestions. If a home visitor makes a suggestion about what a parent can do to help address a child-level need the parent has expressed, the parent might not really understand how to incorporate that suggestion into everyday life. For example, the parent might say she wants her child to be able to scoop oatmeal with a spoon and feed herself with little spilling. The home visitor might tell the parent about providing full physical assistance in the form of hand over hand, then fading the assistance by moving the prompt up the arm. Let us assume the home visitor makes this suggestion well, offering to demonstrate and to give feedback as the parent tries it. If the parent indicates, on a subsequent home visit, that she did not really understand the timing involved in this prompt-fading procedure, and that she is frustrated because she feels she is not teaching her child effectively, the home visitor can offer to teach her the prompt-fading procedure more systematically. This concept of moving from suggestion only to parent training is discussed in the section "Three Tiers for Response to Intervention" section later in this chapter.

A third reason to incorporate actual parent training might be because a desired child behavior is of very high priority for a family. They might be very bothered by the child's inability to perform a skill, by the child's behavior, or by external pressure for the child to be able to perform a skill. For example, a grandparent of the child's might be putting the pressure on the parents, or the child care program is withholding promotion to the next age group until the child learns some particular skills. When the family has placed a child skill as a high priority, they might want more systematic help than simply suggestions. Therefore, if the child has great difficulty in learning a skill, the parent has difficulty in learning an intervention, or the skill has assumed a mighty importance, systematic instruction of parents might be warranted.

Key Child-Instruction Strategies

What are important intervention skills, cutting across routines and developmental domains, for parents to learn?

The first is incidental teaching as described in the 1970s by Hart and Risley (1974; 1975). Although originally designed for teaching language, this strategy can be applied across routines and domains. It involves setting up the environment, if necessary; observing the child's engagement (i.e., what the child is interested in); and eliciting a specific behavior, longer engagement, or more sophisticated

engagement (McWilliam, Wolery, & Odom, 2001). The home visitor first teaches the parent to observe the child's engagement by noting what the child is looking at, what objects he or she is handling, or who the child seems interested in. Families thereby learn to answer the question, at any time, "What is my child interested in right now?" The home visitor then teaches parents how to elicit longer interaction with the object (human or material) of the child's interest, more sophisticated interaction, or a specific interaction. Longer interactions involve helping the child see the object or person in a continuously reinforcing light—keeping it interesting. More sophisticated interactions can include adding in language, more differentiated behavior (i.e., doing different things with the person or object), or problem solving with the person or object (such as by making the interaction challenging enough that the child has to figure out how to continue the interaction, but not so challenging that the child gives up).

The second general strategy can be the systematic application of reinforcement principles (Premack, 1959). Parents can be taught to apply reinforcers, to withhold them, to schedule them, to deliver them at different levels of intensity, and so on (Horner, Dunlap, & Koegel, 1988). Families can be taught the general principles of antecedents, behaviors, and consequences (ABC), so they can make their teaching most effective. They learn to pay attention to setting events and discriminative stimuli, to focus on the specific behavior they are teaching the child to engage in, and to ensure they are providing reinforcers for skills they want to see more of and withholding sometimes inadvertently reinforcers for actions they want to see less of.

The third strategy might be time delay, which is not simply waiting for a response. It is the planned timing between the task direction (e.g., "Time to eat") and the controlling prompt (e.g., taking the child by the hand and leading him or her to the table) (Wolery, Anthony, Caldwell, Snyder, & Morgante, 2002). The home visitor might teach the parent to have no time between the task direction and the controlling prompt, so "errorless learning" occurs; the child doesn't have a chance to make a mistake. Gradually, the delay between the task direction and the prompt is increased, as the child becomes more competent at the skill.

All three of these strategies, incidental teaching, reinforcement, and time delay, are *teaching* strategies that can be used across routines and domains. Home visitors vary greatly in their knowledge of specific teaching strategies and, perhaps more important, in their ability to educate adults on how to use them.

Three Tiers for Response to Intervention

Home visits should be tailored to the family's interests, including their interest in learning specific strategies or techniques to use with the child. One approach to this might be to adopt the three-tiered approach common in school psychology (Kratochwill, Albers, & Shernoff, 2004) and the response-to-intervention framework in school-age special education (Danielson, Doolittle, & Bradley, 2007;

Gresham, 2007). This approach is commonly depicted as a triangle with universal and preventive services in the bottom section. If those services are not effective, a set of intervention services is offered—the middle section of the triangle, showing that this is for a smaller number of children or families. Finally, Tier 3 is the top of the triangle, where intensive, highly individualized services are offered. A model for parent education, following the three-tier model, in the context of preschool (children ages 3–5 years) services, has been proposed (McIntyre & Phaneuf, 2007); it consists of (1) "family-focused early childhood education; self-administered parent education materials"; (2) "group-based parent education"; and (3) "1:1 support" (p. 218). A home-based model for families of infants and toddlers receiving Part C services could also use the three-tier approach (see Figure 8.2).

Regular home visits, as described in this chapter, can be offered to all families in Part C. This is the least intrusive level or tier. As the home visitor makes sug-

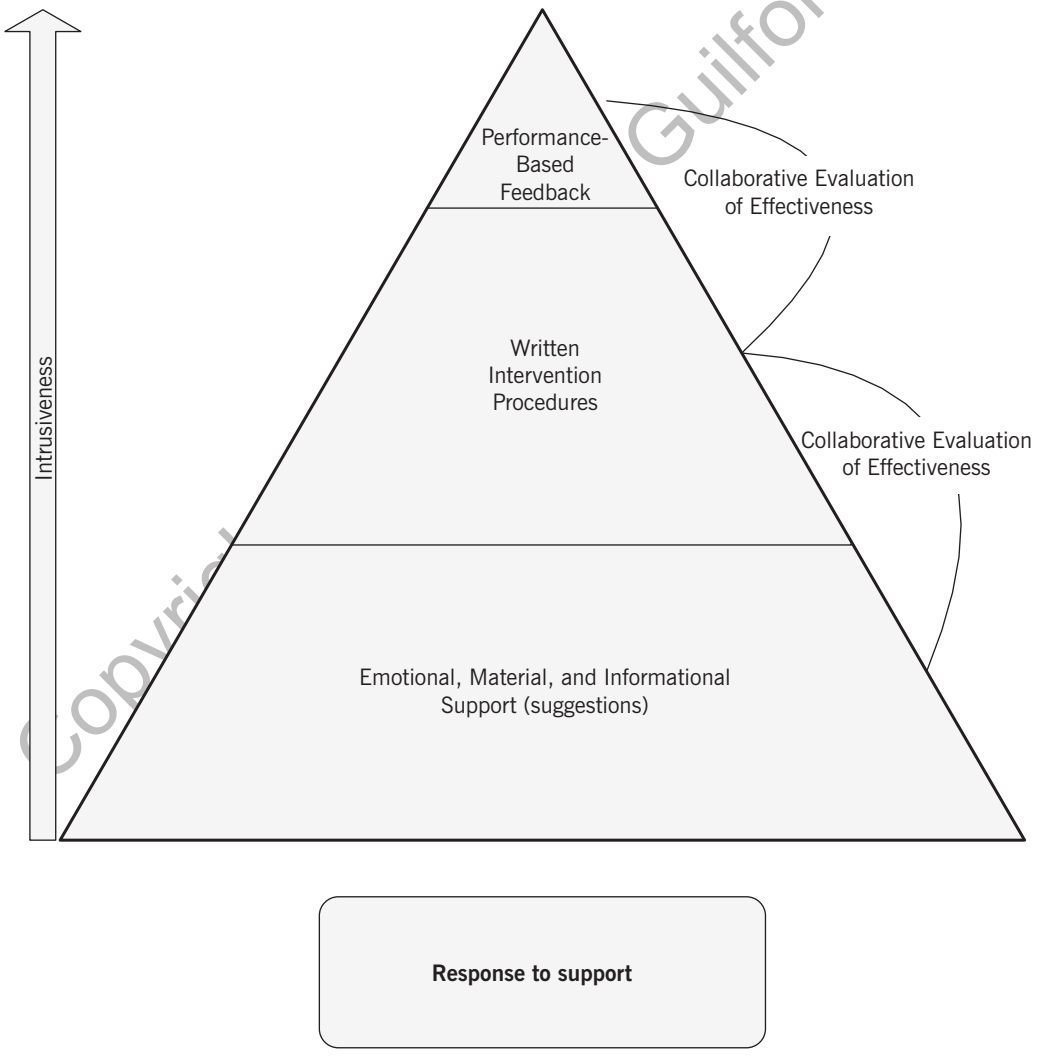

FIGURE 8.2. Response to support.

gestions, as part of providing support, together he or she and the parent ask, "Is this level of support working for the family in terms of parent implementation or of child performance for each outcome?" If the answer is "yes," Tier 1 continues for each outcome. If, for one or more outcomes, the answer is "no," the home visitor provides the family with written or symbolic intervention procedures. Symbolic procedures might be visual schedules or task analyses, which might be helpful for people who do not read the home visitor's language. If this level is mutually determined not to be effective, the family is offered a more intensive and intrusive form of support: performance-based feedback.

Training Parents through Performance Feedback

Parent education is a controversial issue in early intervention. Some experts believe that it is a narrow and paternalistic role to take with families (Dunst, 1999). Other experts believe that it is the essence of supporting families who want to know what to do with their child (Kaiser et al., 1999; Mahoney et al., 1999). It is possible that the response-to-support model proposed in this chapter allows for both perspectives, beginning with the proactive, unintrusive approach and moving to more of an educational, intrusive approach, as the families request it.

Performance feedback is the systematic delivery of information to a learner about his or her actions. When working with parents in home visits, three dimensions of feedback need to be considered. First, checklists can be developed to lay out the steps of the intervention with the child, to provide a platform for giving feedback, and to monitor the parent's performance to know whether the intervention is being carried out as planned. Second, the home visitor uses the checklists to observe the parent showing how he or she intervenes with the child during the week when the home visitor is not there. The home visitor then provides specific feedback, based on the checklists. Third, the family uses the checklists for self-monitoring, which will be successful for some families and not for others. Using checklists, observing, giving feedback, and supporting self-monitoring can all be done in a family-centered manner, if the family wants this level of training.

An example of the use of feedback would be if the family decided they wanted to know how to wash their child's hair in a way that didn't cause the child to scream and kick. The home visitor had tried various suggestions (Tier 1) and had given the family some written guidelines (Tier 2), but the family felt they were not doing it right, because the child was still screaming and kicking. The home visitor then observed bathing and talked to the parents at length about how the bath-time routine worked. This is essentially a functional behavior assessment, producing the finding that the child screamed and kicked to avoid getting his hair wet. This is known as an escape function for the behavior. The home visitor then proposed a bath-time procedure with very detailed steps. The procedure involved setting a fun bath-time atmosphere and then shaping the child's tolerance of wet hair. At first, the parent was instructed to place a wet hand on the back of the child's hair and also instructed on how to document what the parent did and what

the child did. Data collection is very important in parent training through performance feedback. The home visitor taught the parent how the child had to tolerate having a wet hand on his head for three consecutive bath times before the parent moved on to the next level, which was to use a hand to drip water on to the back of the child's head. The home visitor explained that, over several weeks, as the child became more tolerant of these little steps toward getting hair wet, the amount of water increased. The feedback the home visitor provided was based on both the data the parent collected during the week and on the home visitor's observation of the parent's teaching the child. Parent training through feedback is an intensive level of support to families, so it is reserved for situations where easier and less invasive strategies have not worked.

CHALLENGING SITUATIONS IN HOME VISITING

Some families provide especially challenging situations for home visitors. These can be the most interesting and simpáticas families. Four types are discussed.

Families Who Don't Follow Through with Interventions

When this happens, it is the home visitor's responsibility. Blaming the family is not only countertheoretical but futile. The three most common reasons for families not to follow through are (1) the outcome has little meaning, (2) the suggested intervention does not fit into the family's routine or frame of reference, and (3) they have competing priorities. This indeed is the order in which to address the lack of follow through. First, interventionists should ensure the outcomes are derived from needs the family has identified in a routines-based assessment. Next, interventionists should try different suggestions for the family. Finally, interventionists should rethink how they are supporting the family. If the family has competing priorities, interventionists can support the families with those priorities, if they are appropriate; this is, after all, a family-centered service. Interventionists should know that their ethical obligation is to ensure the family has information. For example, if the family is not working on skills they have themselves identified as important, interventionists can gently point out the likely consequences. It is extremely important to be ethical about providing this information, because families' failure to "follow through" is not usually neglect or a life-or-death situation.

Families Who Have Been Coerced into Services

Some families receive home visits because they were referred to early intervention by the public social services agency. These families might believe there is nothing wrong with their child, they might not trust the early intervention professionals, and they might resent having to receive these services. Even when they are told

the program is voluntary, they might (perhaps accurately) perceive participation to be obligatory if they are to keep their children. The four keys to making successful home visits with such families are as follows.

1. Conduct a Routines-Based Interview, because this focuses on what the parent wants the child and other family members to do to make routines more satisfactory. It does not assume a disability.
2. Work to ensure the family understands that the home visitor is there to make the life of the family more pleasant, as defined by the family.
3. Be prepared to spend much energy on fostering a personal relationship with the parent and on helping the family secure resources such as governmental support.
4. Offer the family almost unconditionally positive feedback about what they do with their children. This builds the relationship to the point where suggestions for different approaches can be made successfully.

In general, families who do not know why they are in early intervention need to be supported through the first few visits, until they like the home visitor, even if they cannot identify why he or she comes to the home!

Families with Multiple or Complex Needs

Home visitors who are used to dealing primarily with developmental skills can sometimes be overwhelmed when families have multiple or complex needs, such as poverty-related stresses, intra- or extrafamilial conflict, or medical needs of the child or other family members. Many home visitors are trained in child-related topics other than medical needs, so these family-related and medical issues are frightening in their unfamiliarity, chronicity, and severity. On home visits to such families, it might be helpful to ask all the other questions before Question 3 on the VHVS to ensure the family's priorities are addressed. This helps prevent regression to the familiar by the home visitor who might be more comfortable with child outcomes. If the IFSP had been done well, of course, the IFSP would address these complex needs.

Families Who Want More Than We Have to Offer

Particularly challenging are families who want many services and lots of them. Early intervention programs might not offer that level of service either because of capacity or because of a different interpretation of how children learn and how services work. Families who believe that more is better (McWilliam, Young, & Harville, 1996) might attribute child progress to periodic (e.g., weekly) services, rather than the ongoing interactions the child has with the environment. It is understandable, then, that they might think that the child should get as many of these services

as possible. They presumably correctly interpret 1 or 2 hours a week of *intervention* as insufficient for a child. Unfortunately, the level of *service* a child would need would be so huge to make a difference in his or her learning and development (e.g., perhaps 15 hours a week or more), that that level of service would be unattainable through home visits. If early interventionists are unsuccessful in explaining to families that home visits are designed to prepare natural caregivers for all the time between home visits, those families might be better served through a group-care program, where the child will have other adults involved for enough hours in the day to have a direct impact. Therefore, home visitors working with families wanting many hours of service should, first, attempt to explain to families how children learn and how services work and, second, suggest to families that group care might be an option. They should not blindly apply more services, which can do harm: It can teach families that young children learn from massed trials out of context. It is more supportive of families to teach them that children learn through dispersed trials in context.

CONCLUSION

To serve families well in home visits, it is recommended that professionals

- Use accessible materials rather than a toy bag.
- Engage in "kitchen talk," paying attention to all the family needs that affect the child's development, rather than working just with the child.
- Encourage families through emotional support.
- Work on sensible, helpful goals that improve families' satisfaction with their routines (i.e., quality of life) and follow the Vanderbilt Home Visit Script.
- Find out what families want to be shown and model as necessary and deliberately, rather than modeling unnecessarily.
- Talk about everyday routines (what happens *between* home visits) and talk to families, rather than implying that "lessons" or "sessions" are important and "working with" the child.
- Keep the focus on learning opportunities that occur naturally in family routines as opposed to taking early intervention activities and placing them in routines.

REFERENCES

Bailey, D. B., Jr., Aytch, L. S., Odom, S. L., Symons, F., & Wolery, M. (1999). Early intervention as we know it. *Mental Retardation and Developmental Disabilities Research Reviews, 5*, 11–20.

Bruder, M. B. (2000). Family-centered early intervention: Clarifying our values for the new millennium. *Topics in Early Childhood Special Education, 20*, 105–115.

Bruder, M. B., & Dunst, C. J. (2006). Early intervention service coordination models and service coordination practices. *Journal of Early Intervention, 28*, 155–166.

Campbell, P. H. (1987). The integrated programming team: An approach for coordinating professionals of various disciplines in programs for students with severe and multiple handicaps. *Journal of the Association for Persons with Severe Handicaps, 12*, 107–116.

Danielson, L., Doolittle, J., & Bradley, R. (2007). Professional development, capacity building, and research needs: Critical issues for response to intervention implementation. *School Psychology Review, 36*, 632–637.

de Kruif, R. E. L., & McWilliam, R. A. (1999). Multivariate relationships among developmental age, global engagement, and observed child engagement. *Early Childhood Research Quarterly, 14*, 515–536.

Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., et al. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse and Neglect, 28*, 597–622.

Dunst, C. J. (1999). Placing parent education in conceptual and empirical context. *Topics in Early Childhood Special Education, 19*, 141–147.

Dunst, C. J. (2001). Participation in community learning activities. In M. J. Guralnick (Ed.), *Early childhood inclusion: Focus on change* (pp. 307–336). Baltimore: Brookes.

Dunst, C. J., Hamby, D., Trivette, C. M., Raab, M., & Bruder, M. B. (2002). Young children's participation in everyday family and community activity. *Psychological Reports, 91*, 875–897.

Dunst, C. J., & McWilliam, R. A. (1988). Cognitive assessment of multiply handicapped young children. In T. D. Wachs & R. Sheehan (Eds.), *Assessment of young developmentally disabled children* (pp. 213–238). New York: Plenum Press.

Dunst, C. J., & Trivette, C. M. (1988). Helping, helplessness and harm. In J. Witt, S. Elliott, & F. Gresham (Eds.), *Handbook of behavior therapy in education* (pp. 343–376). New York: Plenum.

Edelman, L. (2001). *Just being kids: Supports and services for infants and toddlers and their families in everyday routines, activities, and places* [Videotape with facilitator's guide]. Denver, CO: Western Media Products.

Gelfand, D. M., Teti, D. G., Seiner, S. A., & Jameson, B. (1996). Helping mothers fight depression: Evaluation of a home-based intervention program for depressed mothers and their infants. *Journal of Clinical Child Psychology, 25*, 406–422.

Greenwood, C., Walker, D., Bailey, D., & ECO Center Colleagues (2005, October). *Critical issues in measuring outcomes for young children and their families.* Paper presented at the Annual Meeting of the CEC Division for Early Childhood Conference, Portland, OR. Retrieved April 30, 2006, from *www.fpg.unc.edu/~ECO/presentations.cfm*.

Gresham, F. M. (2007). Response to intervention and emotional and behavioral disorders: Best practices in assessment for intervention. *Assessment for Effective Intervention, 32*, 214–222.

Grisham-Brown, J. C., Schuster, J. W. C., Hemmeter, M. L. C., & Collins, B. C. (2000). Using an embedding strategy to teach preschoolers with significant disabilities. *Journal of Behavioral Education, 10*, 139–162.

Guralnick, M. J. (1998). Effectiveness of early intervention for vulnerable children: A developmental perspective. *American Journal on Mental Retardation, 102*, 319–345.

Guralnick, M. J. (2001). A framework for change in early childhood inclusion. In M. J. Guralnick (Ed.), *Early childhood inclusion: Focus on change* (pp. 3–38). Baltimore: Brookes.

Hanft, B. E., & Feinberg, E. (1997). Toward the development of a framework for determining the frequency and intensity of early intervention services. *Infants and Young Children, 10*, 27–37.

Hanft, B. E., Rush, D. D., & Shelden, M. L. (2004). *Coaching families and colleagues in early childhood*. Baltimore: Brookes.

Harbin, G. L. (2005). Designing an integrated point of access in the early intervention system. In M. J. Guralnick (Ed.), *The developmental systems approach to early intervention* (pp. 99–132). Baltimore: Brookes.

Hart, B., & Risley, T. R. (1974). Using preschool materials to modify the language of disadvantaged children. *Journal of Applied Behavior Analysis, 7*, 243–256.

Hart, B., & Risley, T. R. (1975). Incidental teaching of language in the preschool. *Journal of Applied Behavior Analysis, 8*, 411–420.

Horner, R. H., Dunlap, G., & Koegel, R. L. (Eds.). (1988). *Generalization and maintenance: Lifestyle changes in applied settings*. Baltimore: Brookes.

Jung, L. A., & McWilliam, R. A. (2005). Reliability and validity of scores on the IFSP Rating Scale. *Journal of Early Intervention, 27*, 125–136.

Kaiser, A., Mahoney, G., Girolametto, L., MacDonald, J., Robinson, C., Safford, P., et al. (1999). Rejoinder: Toward a contemporary vision of parent education. *Topics in Early Childhood Special Education, 19*, 173–176.

Kendrick, D., Elkan, R., Hewitt, M., Dewey, M., Blair, M., Robinson, J., et al. (2000). Does home visiting improve parenting and the quality of the home environment? A systematic review and meta analyis. *Archives of Disease in Childhood, 82*, 443–451.

Korfmacher, J., Kitzman, H., & Olds, D. (1998). Intervention processes as predictors of outcomes in a preventive home-visitation program. *Journal of Community Psychology, 26*, 49–64.

Kratochwill, T. R., Albers, C. A., & Shernoff, E. S. (2004). School-based interventions. *Child and Adolescent Psychiatric Clinics of North America, 13*, 885–903.

Liaw, F., Meisels, S. J., Brooks-Gunn, J. (1995). The effects of experience of early intervention on low birth weight, premature children: The infant health and development program. *Early Childhood Research Quarterly, 10*, 405–431.

Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., et al. (2005). The effectiveness of Early Head Start for 3-year-old children and their parents: Lessons for policy and programs. *Developmental Psychology, 41*, 885–901.

Mahoney, G., Kaiser, A., Girolametto, L., MacDonald, J., Robinson, C., Safford, P., et al. (1999). Parent education in early intervention: A call for a renewed focus. *Topics in Early Childhood Special Education, 19*, 131–140.

McBride, S. L., & Peterson, C. (1997). Home-based early intervention with families of children with disabilities: Who is doing what? *Topics in Early Childhood Special Education, 17*, 209–233.

McIntyre, L. L., & Phaneuf, L. K. (2007). A three-tier model of parent education in early childhood: Applying a problem-solving model. *Topics in Early Childhood Special Education, 27*, 214–222.

McWilliam, R. A. (1992). *Family-centered intervention planning: A routines-based approach*. Tucson, AZ: Communication Skill Builders.

McWilliam, R. A. (1998). *The rules: Family-centered practices in different early intervention service delivery models.* Georgia Association on Young Children 32nd Annual Conference, "Natural Environments: Interventions Where They Count" [featured speaker], October 9, 1998, Atlanta, GA.

McWilliam, R. A. (2000). It's only natural . . . to have early intervention in the environments where it's needed. In S. Sandall & M. Ostrosky (Eds.), *Young exceptional children monograph series no. 2: Natural environments and inclusion* (pp. 17–26). Denver, CO: Division for Early Childhood of the Council for Exceptional Children.

McWilliam, R. A. (2002, June). *Support-based home visits.* Paper presented at the annual meeting of the National Early Intervention Association. Coimbra, Portugal.

McWilliam, R. A. (2003). Giving families a chance to talk so they can plan. *News Exchange* [newsletter of the American Association for Home-Based Early Intervention], *8*(3), 1, 4–6.

McWilliam, R. A. (2004). *Vanderbilt home visit script.* Center for Child Development, Vanderbilt University Medical Center, Nashville, TN.

McWilliam, R. A. (2005a). Assessing the resource needs of families in the context of early intervention. In M. J. Guralnick (Ed.), *A developmental systems approach to early intervention* (pp. 215–234). Baltimore: Brookes.

McWilliam, R. A. (2005b). *Satisfaction with Home Routines Evaluation (SHoRE).* Vanderbilt University Medical Center, Nashville, TN. Availab;e at *www.siskin.org.*

McWilliam, R. A. (2006). *RBI report form.* Vanderbilt University Medical Center, Nashville, TN. Available at *www.VanderbiltChildrens.org/childdevelopment/.*

McWilliam, R. A., & Bailey, D. B. (1992). Promoting engagement and mastery. In D. B. Bailey & M. Wolery (Eds.), *Teaching infants and preschoolers with disabilities* (2nd ed., pp. 229–256). Columbus, OH: Merrill.

McWilliam, R. A., & Scott, S. (2001). A support approach to early intervention: A three-part framework. *Infants and Young Children, 13*(4), 55–66.

McWilliam, R. A., Snyder, P., Harbin, G. L., Porter, P., & Munn, D. (2000). Professionals' and families' perceptions of family-centered practices in infant-toddler services. *Early Education and Development, 11*, 519–538.

McWilliam, R. A., Tocci, L., & Harbin, G. L. (1998). Family-centered services: Service providers' discourse and behavior. *Topics in Early Childhood Special Education, 18,* 206–221.

McWilliam, R. A., Wolery, M., & Odom, S. L. (2001). Instructional perspectives in inclusive preschool classrooms. In M. J. Guralnick (Ed.), *Early childhood inclusion: Focus on change* (pp. 503–530). Baltimore: Brookes.

McWilliam, R. A., Young, H. J., & Harville, K. (1996). Therapy services in early intervention: Current status, barriers, and recommendations. *Topics in Early Childhood Special Education, 16*, 348–374.

Park, J., Hoffman, L., Marquis, J., Turnbull, A. P., Poston, D. J., Mannan, H., et al. (2003). Toward assessing family outcomes of service delivery: Validation of a family quality of life survey. *Journal of Intellectual Disability Research, 47,* 367–384.

Park, J., Turnbull, A. P., & Turnbull, H. R. (2002). Impacts of poverty on quality of life in families of children with disabilities. *Exceptional Children, 68,* 151–170.

Powell, D. (1993). Inside home visiting programs. *The Future of Children, 3*(3), 1–16.

Premack, D. (1959). Toward empirical behavior laws: I. Positive reinforcement. *Psychological Review, 66*, 219–233.

Risley, T. R., & Cataldo, M. F. (1973). *Planned activity check: Materials for training observers.* Lawrence, KS: Center for Applied Behavior Analysis.

Roberts, R. N., Rule, S., & Innocenti, M. S. (1998). Strengthening the family–professional partnership in services for young children. Baltimore: Brookes.

United States Department of Education. (2003). *Twenty-fifth annual report to Congress on the implementation of the Individuals with Disabilities Education Act.* Washington, DC: Author.

Wolery, M., Anthony, L., Caldwell, N. K., Snyder, E. D., & Morgante, J. D. (2002). Embedding and distributing constant time delay in circle time and transitions. *Topics in Early Childhood Special Education, 22*, 14–25.

Woods, J. J., & Wetherby, A. M. (2003). Early identification of and intervention for infants and toddlers who are at risk for autism spectrum disorder. *Language, Speech, and Hearing Services in Schools, 34*, 180–193.

World Health Organization. (2007). *International classification of functioning, disability and health: Children and youth version icf-cy.* Geneva: WHO Press.