

EARLY HOME BASED INTERVENTIONS WITH
DEVELOPMENTALLY DELAYED YOUNG CHILDREN

CENTRE FOR NEWFOUNDLAND STUDIES

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0-612-54870-8

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Early Home Based Interventions with
Developmentally Delayed Young Children

By

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A thesis submitted to the
School of Graduate Studies
in partial fulfillment of the
requirements for the degree of
Master of Education in Educational Psychology

Faculty of Education
Memorial University of Newfoundland

July 1999

Acknowledgments

I am forever grateful to Dr. Gary Jeffery for his insight and advice throughout the many revisions of this paper folio. Also, to my wife Valerie, and our sons, Jordan and Joshua, without your support this accomplishment would not have been possible. Finally, to my parents, Allan and Gleason, thank you for your encouragement.

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Preface

This paper folio examines current offerings on early intervention with developmentally delayed preschoolers, giving emphasis to delivering services and supports directly to parents and children in their own homes. This work is deemed important because not all children develop their skills and competencies at the same rate as their same aged peers and it is the task of others to encourage their development and to minimize any developmental lags.

The first paper in this folio, "A Perspective on the Need for Early Interventions with Developmentally Delayed Young Children," provides an overview of the conceptual issues and intervention approaches offered in current literature. From this paper, three critical dimensions of early intervention are derived, namely, the need for an individualized curriculum, assessment, and parental involvement. Paper one then examines services delivered directly to children and parents in their homes and other programs that directly involve parents but are not exclusively home based.

Paper two of this folio, "Toward the Most Appropriate Practices for Intervening with Developmentally Delayed Young Children and Their Families," utilizes the critical dimensions of early intervention derived in paper one to examine two major documents offered as useful in designing and evaluating programs for young children at national and regional levels. The documents are examined individually and compared and contrasted based upon these critical dimensions of early intervention.

Finally, paper three of this folio examines a regional approach to early intervention with developmentally delayed young children. The recently modified Direct Home Services Program in the Province of Newfoundland and Labrador is examined. The original and new approaches to early intervention are compared and examined utilizing the critical dimensions of early intervention derived and utilized in papers one and two of this folio. Predictions are made about the probable relative effectiveness of the modified approach. Recommendations for future research are also made.

**A Perspective on the Need for Early Interventions with
Developmentally Delayed Young Children**

It has been recognized for many years that early education and early intervention programs can reduce the number of children who require intensive long term help (Jordan, Hayden, Karnes, & Wood, 1977). Indeed, while much research demonstrates that many different forms of early intervention can yield positive results, it is impossible to make the unqualified statement that all early intervention programs are beneficial (Berrueta-Clemment, Schwenhart, Barnett, Epstein, & Weikart, 1984; Gersten, Darch, & Gleason, 1988; Innocenti & White, 1993; Schweinhart, Barnes, & Weikart, 1993; Wasik & Slavin, 1993).

It is especially critical to intervene early in the life of children who are developmentally delayed if they are to be provided with the tools necessary to develop to their full potential. Meisels and Shonkoff (1990) point out that a vast amount of literature documents the need for early intervention with children who fall into this category. Much of this literature is based on the premise that children who do not acquire typical early childhood skills are disadvantaged with respect to learning more advanced skills later on. Thus, intervention should occur to encourage development of the early skills within the context of the child's overall development (Noris, 1991). As a result of such early intervention, many children function at levels beyond what, in previous years, were deemed possible (Hedge & Johnson, 1986; Ramey & Ramey, 1992). Helping children develop to their fullest potential before entering kindergarten enables them to meet with greater success in school. The more skills a child has developed before entering kindergarten, the fewer the demands placed on the system for individual and remedial supports. While providing educational resources to developmentally delayed preschoolers and their families can, in the long term, decrease the costs of education such children, it is the individual benefits to children that must guide the development and implementation of early childhood education and intervention programs (Meisels & Shonkoff, 1990).

In a review of educational programs for developmentally delayed young children, Seitz (1990) states that there is a common thread of success throughout intervention programs. Children who, as preschoolers, participated in an early education program were less likely to be placed in special education classes or be retained in the same grade for a second year. Several authors assert that early intervention better equips special needs children to meet with success in school and that early intervention has some positive impact (Marfo, K., Brown, N., Gallant, D., Smyth, R., Corbett, A., & McLennon, D., 1988; Seitz, 1990). It is on this basis that early childhood special education (ECSE) practitioners undertake to help developmentally delayed young children and their families.

It is important that these early interventions be appropriate for the child's current developmental level. Bredekamp (1987) emphasizes this point when she states that we should shudder at those who would teach 4-year-Olds like fourth graders (and) shake our heads when 18-month-Olds are expected to function like 4-year-Olds. Development is a truly fascinating and wonderful phenomenon. It is not something to be accelerated or skipped. One period of childhood or aspect of development is not better or more important than another; each has its own tasks to accomplish. (p. iv)

This paper focuses on what should be done when a child's chronological and developmental levels are not the same. A perspective is offered on the conceptual issues related to early intervention with developmentally delayed young children. Particular attention is paid to programs where parents are the primary providers of intervention and services are provided to the parents and children in their own home. In these "direct home service" (DHS) programs trained individuals periodically visit the homes to instruct parents in providing early educational intervention to their developmentally delayed

children.

This paper is based on the assumptions that developmentally delayed young children benefit from sustained, consistent and age-appropriate experiences and that optimal experiences for children require careful attention to the children's individual strengths, weaknesses and overall developmental levels. Because parents love their children and are motivated to support them and because parents can typically spend more time with their children than professionals, parents are in a position to offer services, especially if technically and emotionally supported.

When working with any special education group, clear terminology is necessary. The American Association on Mental Retardation (AAMR) (1992) defines mental retardation as:

...substantial limitations in present functioning. It is characterized by significantly sub average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18. (p. 1)

The AAMR outlines four criteria that must be utilized in applying the definition. They state that:

1. Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioral factors;
2. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs of supports;
3. Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities; and

4. With appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve. (p. 5)

Marfo and colleagues (1988), citing the work of Bernheimer and Keogh, define developmental disabilities as "...chronic disabilities which result from mental and/or physical impairment and manifest themselves in substantial functional limitations in such areas as academic skills, communication, ... social skills, mobility, self-care, and capacity for independent living" (p. 6). Children in this category include those with Down's syndrome, autism, spinabifida, and cerebral palsy. Marfo and colleagues, further citing the same work, state that a developmental delay exists in children when they "...manifest signs of slow development and language/communication problems, but ...exhibit no clear signs of associated physical or biological impairments" (p. 6).

In this paper, the term "developmental delay" is defined as the condition of having a pronounced and significant lag in the emergence of language, motor, self-help, cognitive, or social skills as compared to one's same-aged peers. The term is an all-inclusive one which addresses children labelled as mentally retarded as per the AAMR definition (1992), developmentally disabled, and developmentally delayed (Canning & Lyon, 1991; Marfo et al., 1988).

The target group focussed upon in this paper is developmentally delayed children below school age who, for various reasons, are not acquiring skills at the same pace as their same-aged peers. This is also the population of children whose needs are often being addressed by the types of early intervention services discussed throughout this folio.

Early Intervention - Delivery Considerations

There are two main premises on which early intervention (EI) is hinged. The first can be

expressed in terms of the AAMR's (1992) fourth criteria for application of its definition of mental retardation, which states that when intervention occurs in an appropriate manner, there will generally be improvement in some aspect of life functioning. The second premise is that intervention must occur relatively early in life. Bricker and Veltman (1990) rather succinctly state that:

Two theoretical assumptions appear to have provided the basic rationale for the development of child-focused early intervention programs: (1) genetic and biological problems can be overcome or attenuated and (2) early experience is important to children's development. (p. 374)

While EI is recognized as necessary, it is beyond the scope of this paper to discuss in detail the nature of such interventions. Paper two in this folio, entitled "Toward Appropriate Practices for Intervening with Developmentally Delayed Young Children and Their Families," will discuss principles and guidelines to be utilized when developing and delivering EI programs. Below is an overview of the broader conceptual issues and the intervention approaches used with the group.

Much has been written in the Early Childhood Special Education literature about the appropriate processes of EI with developmentally delayed children (Carta, 1995). Wolery & Bredekamp (1994) offer seven outcomes as defensible goals for programs supporting developmentally delayed children and their families. They suggest that programs should seek:

1. To support families in achieving their own goals,
2. To promote children's engagement, independence, and mastery,
3. To promote children's development in key domains,
4. To build and support children's social competence,

5. To promote children's generalized use of skills,
6. To provide and prepare children for normalized life experiences, and
7. To prevent the emergence of future problems or disabilities.

Wolery & Bredekamp emphasize the relevance of child-specific or individualized practices when they state that professionals should take into account the characteristics of the individual child and the dynamics of the family structure.

The National Association for the Education of Young Children (NAEYC) in its "Position Statement on School Readiness" (1990) expresses its view in more general terms. It states that successful intervention efforts have commonalities in that they provide comprehensive services to ensure a wide range of individual needs are met, strengthen the role of parents as first teachers, and provide a wide array of first hand experiences and learning activities either directly to children or through parent education.

Developmentally Appropriate Practice

Any program directed at young children must utilize developmentally appropriate practices, (DAP) (Bredekamp, 1987). Since this term can be mistakenly utilized as all encompassing, such an error can be avoided by defining it in broad terms. Kostelnik (1993) states that "the essence of DAP can be expressed as taking into account everything we know about how children develop and learn, and matching that to the content and strategies planned for them in early childhood programs" p. 3.

Bredekamp, in a document prepared for the NAEYC entitled Developmentally Appropriate Practice in Early Childhood Programs Serving Children From Birth Through Age 8 (1987), states that developmental appropriateness comprises two dimensions: age appropriateness and individual

appropriateness. Age appropriateness refers to the natural and predictable progression or change that occurs in all domains of development (ie. physical, emotional, social, and cognitive). Individual appropriateness takes into account the unique characteristics of each child with respect to background, developmental level, learning style, etc.. Bredekamp emphasizes that early intervention needs to be developmentally appropriate in that it matches intervention practices to the child's level of development. (Note: while space prohibits an extensive discussion about this document here, because of its potential for guiding intervention programs for developmentally delayed children, it is critically reviewed in the second paper of this folio.)

Division for Early Childhood Recommended Practices

In 1991 the Council for Exceptional Children, Division for Early Childhood (DEC) created the "Task Force on Recommended Practices" with the mandate of creating and articulating practice recommendations in early childhood special education. In 1993 it produced a comprehensive document entitled DEC Recommended Practices: Indicators of Quality in Programs for Infants and Young Children With Special Needs and Their Families. The more than 400 recommended practices outlined in the document are subdivided under 14 headings, each with a preamble outlining a rationale for the formulation and utilization of the recommended practice. The 14 subheadings are: Assessment, Family participation, Individual Family Support Plans and Individual Education Plans, Service Delivery Models, General Curriculum and Intervention Strategies, Interventions to Promote Cognitive Skills, Interventions to Promote Communication Skills, Interventions to Promote Social Skills and Emotional Development, Interventions to Promote Adaptive Behavior Skills, Interventions to Promote Motor Skills, Transition, Personnel Competence, Program Evaluation, Early Intervention

with Children who are Gifted. Every "recommended practice," before being labelled as such, had to meet specified criteria. All had to be: research based or value-based; family centered; multi culturally applicable; cross disciplinary oriented; developmentally/chronologically age appropriate; and normalized. (Like the DAP guidelines, the specific DEC recommended practices will be analysed more closely in paper two of this folio.)

Critical Dimensions of Early Intervention

While there are many principles that are important in the provision of early intervention services to developmentally delayed children and their families, it is the author's opinion that three address most of the primary issues in this area. They are individualized curriculum, assessment, and parental or, more specifically, family involvement. Each of these issues is discussed below.

Individualized Curriculum

Young children with developmental delays are deemed to need an individualized program (Bailey & Wolery, 1989; Carta, 1995; Division for Early Childhood, 1993; Safer & Hamilton, 1993; Seitz & Provence, 1990; Turbville, Turnbull, Garland, & Lee, 1993). Such individualization allows for task analysis of more complex skills, adaptation of teaching materials, utilization of various types of individually appropriate prompts, and the assessment of motivational factors especially applicable to the individual child (Carta, 1995).

Goodman & Pollak (1993) place individualization in a different context. They surveyed professionals working with developmentally delayed preschoolers and found that there was much

commonality in curricula used. Their research indicated that the most commonly reported items on the individualized programs/curriculum for these children were of a pre academic nature and were designed to prepare children for kindergarten. Items included the teaching of shapes, colors, quantity, size, and puzzles. Goodman & Pollak question the appropriateness of such an orientation and propose that Individual Education Plan (IEP) items focus on the skills that children are ready and eager to learn, as opposed to what educators believe they should learn. This position is based on the theoretical conceptualizations of the nature of human development, such as those by Piaget (1971). Children must reach certain prerequisite developmental levels before more abstract concepts can be grasped. Developmentally delayed young children will, by definition, typically be older than others before reaching such prerequisite developmental levels or may never reach such levels at all (Goodman, 1994; Goodman & Pollak, 1993). In other words, if early educators set out to teach a specific set of skills (eg. colors, shapes, counting) based on what children at a specific age should typically be able to grasp, then the principles of individualized developmental appropriateness (discussed below) have not been utilized. On the other hand, when intervention programs encourage the development of emerging skills and teach others that the child is developmentally ready to learn, such programs are better poised for success (Goodman, 1994; Goodman & Pollak, 1993). Such emerging skills and developmental levels are determined through a comprehensive individualized assessment (Notari, Slentz, & Bricker, 1991).

Assessment

Individualized assessment is necessary if interventions are to address the child's relative strengths and weaknesses (Neisworth, 1993; Notari, Slentz, & Bricker, 1991). It is best if such

assessment is done in natural settings (e. g. homes) with input from parents (Bredekamp, 1987; DEC, 1993; Neisworth, 1993; Wolery, 1996). An appropriate assessment will offer insight into how skill development can be encouraged without attempting to "teach" skills in isolation from other skills and interactions and, as discussed above, take into account individual developmental differences (Noris, 1991). Also, assessment must be repeated frequently to monitor the child's progress and to assess the effectiveness of the offered interventions (Bagnato & Neisworth, 1991; DEC, 1993; Wolery, Werts, & Holcombe, 1994).

Parental Involvement

While professionals in the area of early childhood education are, by virtue of their occupation and training, viewed as more knowledgeable regarding specific handicapping conditions and appropriate intervention strategies (Farran, 1990), family members are the most consistently available teachers in the lives of developmentally delayed children (Kotliarenco, Fuentes, Mendez, 1990; Seitz & Province, 1991; Shriver, Kramer, & Garnett, 1993; Winton, 1996). Furthermore, the most effective early intervention strategies are those which view children within the context of their families (Guralnick, 1989; Kassebaum, 1994; Mitchell & Brown, 1991). Able-Boone, Goodwin, Sandall, Gordon, & Martin (1992) found that parents of developmentally delayed young children desire to be actively involved in their children's learning and desire an ongoing structured plan of involvement. By involving, supporting, and educating the parents, lifelong interventionists are being provided to the children.

A partnership in which the parents and professionals work together is beneficial to all participants, especially the child (Bredekamp, 1987; DEC, 1993; Seitz & Province, 1990) and a

“family focus” is of paramount importance in early childhood intervention (Westling, 1996). Parents bring to the intervention process information about strengths, weaknesses, likes, dislikes, medical background, and family circumstances. All of these must be considered if the interventions are to be effective (Hornby, 1991). Such a focus gives recognition that the family is at the center of children’s lives (National Child Care Information Center, 1997). A true partnership goes beyond keeping parents educated and informed about programs serving their children. The optimal situation is when parents are actively involved in their children’s programs by making decisions, giving direction, and effecting change when priorities are not being met (National Child Care Information Center, 1997).

Home Based Services

Home based services are those which are delivered directly to children and families in the natural setting of their home. While Able-Boone and colleagues (1992) found that both parents and professionals were more pleased with home based services than center based services, other researchers have found that not all parents are able or willing to be primary participants in working with their children (DEC., 1993; Seitz & Provence, 1990). Some children may be reluctant to try and learn when the parent is the teacher. Such lack of learning can result in stress between parents and children that may hinder effective intervention (Seitz & Provence, 1990). Nevertheless, involvement of parents is a major reason cited for the success of home based intervention (Bekman 1990).

Much of the research into providing home based intervention has originated in the United States. As Marfo (1991) points out, Canada’s proximity to the United States has been both a blessing and a curse. A blessing because we tend to benefit from recent progressive trends in U.S. law and

practices regarding services for all developmentally delayed children. It is a curse because we have tended to be complacent, and have become dependent on the U.S. for initiatives in this area. In Canada we have relatively fewer homemade laws and guarantees aimed specifically at addressing the needs of our children. Marfo (1991) points out that many school boards throughout Canada have shaped policies based upon popular U.S. laws (eg. P.L. 94-142) as if they were Canadian laws, leaving little legal protection for these policies should they be challenged in court. Early childhood special education services are no exception to this pattern.

Portage Project

The home-based intervention service that has had the most impact on the development of Canadian intervention services is the Portage Project (Marfo, 1991). This program was initiated in the early 1970's in south central Wisconsin as a home-based service to children with disabilities who lived in rural areas (Herwig, 1998). It is based on a demonstration model of intervention which, according to Sturmev (1991), involves

...weekly home visits from a trained home visitor. During this visit the previous week's goals are reviewed, the next teaching goals for the child are negotiated, an activity chart is completed, the teaching method is modeled, and the parent is observed teaching the child. A developmental checklist (Bluma, Shearer, Frohman, & Hilliard, 1976) is used to assess the child at referral, to select goals and to monitor progress. (p. 304)

This skill-teaching approach to intervention, after establishing a child's present developmental level, sets out to actively teach the skills that would typically develop next. The procedure is an

attempt to accelerate the development of the child with a long term goal of decreasing or eliminating the developmental lag. The degree of a child's developmental delay is usually determined by a standardized assessment instrument - e.g. The Alpern-Boll Developmental Profile (Alpern & Boll, 1972). Detailed reviews of this project are offered elsewhere by Sturmeijer (1990,1991) and his colleagues (1986).

The Portage Project is child focused as opposed to family focused. The parents are viewed as teachers following the directions given by the trained home visitor. While modern trends in early intervention with developmentally delayed children put a greater importance on the desires and needs of the family as a whole (Kassebaum, 1994; Mitchell & Brown, 1991), it is important to emphasize that this program, simply by actively involving parents in the process, was important in stimulating this paradigm shift. The third paper in this folio elaborates on this paradigm shift in the Direct Home Services Program in the province of Newfoundland and Labrador.

Levenstein's Verbal Interaction Project

Another home based project is the less well-known Levenstein's Verbal Interaction Project, carried out in the early 1970s (Seitz & Provence, 1990). In this program, home visitors called Toy Demonstrators visited the homes of children who were suspected of being developmentally delayed due to a lack of cognitive stimulation. The Toy Demonstrator would bring individually matched toys and demonstrate how they were played with and would encourage parents to interact with their children, using the toys as the focal point of the interaction. This program recognized the need for parent involvement, carefully matched and sequenced resources, individualized curricula, and the benefits associated with extra-family support.

Programs Incorporating Parental Involvement

Toy Libraries

Another approach to intervention involves the use of toy-libraries. Mayfield (1993) surveyed Sweden, England, Canada, and Australia to determine the prevalence and characteristics of toy libraries in those countries. She found that out of the 32 established toy libraries "...approximately half were community-oriented toy libraries and half were primarily or exclusively for special needs children and their families" (p. 4). She found Sweden to be the only country in which toy libraries predominantly served special needs children and their families. In essence, the primary goal of most of these libraries is to "provide toys to children without toys including special needs/adapted toys" (p. 7). Also, there was often included a family focused/parent education component.

Perry Preschool Project

This longitudinal project (Schweinhart, Barnes, & Weikart, 1993) involved 123 impoverished American preschool children who lived in the neighbourhood of the Perry Elementary School in Ypsilanti, Michigan, in the 1960's. The children were assigned to either the "program" (experimental) group or the "no-program" (control) group and were followed for nearly three decades. All the children were 3 and 4 years old at the beginning of the study and were described as intellectually challenged and had IQ scores between 60 and 90.

Children in the "program" group were enrolled in an active learning preschool program which involved attending preschool for 2 ½ hours per day, five days per week. In addition, a 90 minute

weekly home visit was made to keep parents informed of their child's activities and progress and to encourage the parents to participate in the educational process. Children in the "no-program" group did not attend the preschool, nor were any home visits made. Long term follow-up has demonstrated significant differences between the experimental and control groups on various factors. Members of the experimental group were less likely to be in trouble with the law or to have received Social Assistance. Those in the experimental group were also more likely to graduated from high school, earned more money, and to own their own homes. Based on this project, it is impossible to comment on the relative impacts of preschool attendance and the home visits.

Conclusions

Stimulating environments and early intervention programs for developmentally delayed children typically have some positive impact (Marfo et. al, 1988). Parent participation in such programs is believed to be important and much of the literature calls for a partnership between parents and the other participants (Bredekamp, 1987; DEC, 1993; Seitz & Province, 1990). Intervention goals and strategies for developmentally delayed children are best achieved when they are individualized and matched with the child's present developmental level(Bredekamp, 1987; Carta, 1995; Kostelnik, 1993). This matching is accomplished after a careful, multifaceted assessment of the child, including assessment under natural conditions with input from parents (DEC, 1993; Noris, 1991; Wolery, Werts, & Holcombe, 1994). Thus, from the relatively limited amount of research in this field, three critical dimensions of early intervention with developmentally delayed children and their families appear to be parental involvement, individualized curriculum, and assessment.

Home based services are one method of addressing these critical dimensions of intervention.

The assessment will occur in the most natural setting, the home, with the participation of parents. Bringing the service to the parents, as opposed to bringing parents (and children) to the service, underscores the importance of a partnership approach to early intervention. Furthermore, by carrying out the interventions in the home, familiar items can be utilized and incorporated into the intervention strategies and techniques.

Much more research is needed in this area to determine the most effective methods of early intervention. This will require longitudinal studies that control extraneous factors. Carrying out such research without withholding some of what is believed to be best practices will be an ethical and logistical challenge. The practical, ethical, financial, and political difficulties associated with such research may explain why scientific study in this field is limited.

**Toward the Most Appropriate Practices for Intervening with Developmentally
Delayed Young Children and Their Families**

Having a frame of reference to give us criteria against which to judge how well we are doing helps in our strive towards excellence (Miller, 1992). A seemingly unrelated point is that parents want to participate more fully than just as required for the IEP; they want to learn and be informed about best practices in working with their developmentally delayed children (Williams, Fox, Thousand, & Fox, cited in Westling, 1996). When considered together, these points suggest that it is important that early intervention services for developmentally delayed children be provided from a common vantage point and be coordinated (Bredenkamp, 1987; Westling, 1996). To help establish such a frame of reference, this paper will analyze the literature on what some regard as the best practices to be followed when intervening with developmentally delayed young children and their families. Identifying best practices is not a simple task, as demonstrated by the many recent authors who have undertaken to do so (DeStefano, Howe, Horn, & Smith, 1990; Hanson, & Lynch, 1989; Odom, McLean, Johnson, & LaMontagne, 1995; Safford, 1989; Wolery, Strain, & Bailey, 1992). The ongoing research and debate demonstrates that, to date, there is a lack of consensus as to what exactly constitutes "best practices," (Eays & Jones, 1992; Odom et. al, 1995; Odom & McLean, 1993). This paper is aimed at seeking points of consensus and thereby contributing to the clarification as to what are the best practices for such interventions.

This paper is based on the premise that developmentally delayed young children benefit from sustained, consistent age-appropriate experiences and that optimal experiences pay careful attention to their developmental level within the context of individual strengths and weaknesses. It assumes as well that carefully prepared intervention strategies, material, and advice are useful. Finally, it assumes that the best location for the delivery of service is in the child's home with parents playing a major role in designing and delivering the specific interventions.

In reviewing the literature on parental involvement in early intervention programs for developmentally delayed young children, aging from birth to five years old, and on in home services for this population, no major documents intended to guide the development and utilization of direct home service programs could be found. Two documents designed to guide development of and implementation of general programs for this age group were found. This paper offers a critical review and comparison of these two documents: Developmentally Appropriate Practices in Early childhood Programs Serving Children From Birth Through Age 8 (DAP), written by the National Association for the Education of Young Children (Bredekamp, 1987, 1997), and the DEC Recommended Practices: Indicators of Quality in Programs for Infants and Young Children With Special Needs and Their Families, written by the Council for Exceptional Children: Division for Early Childhood (DEC Task Force on Recommended Practices, 1993).

Developmentally Appropriate Practice

The document, Developmentally Appropriate Practices in Early childhood Programs Serving Children From Birth Through Age 8 (Bredekamp, 1987), is offered by the National Association for the Education of Young Children, the largest organization of early childhood educators in the United States. It offers recommended practices for working with young children and was written with a group setting in mind (e.g. daycare or preschool). The DAP guidelines were created as a result of concerns related to the wide discrepancies between the methodologies used in early childhood education programs as well as concerns about the use of elementary school methodologies with younger children (Bredekamp & Copple, 1997; Wolery, Werts, & Holcombe, 1994;).

While it is appropriate that any program directed at young children utilize “developmentally appropriate practices,” as Kostelnik (1993) points out, when the term is used in an all encompassing manner problems can ensue. For example the term may be used to “justify readiness programs that structure children’s learning into narrowly defined parameters and ...to rationalize grouping children by ability or by almost anything *other* than ability” (p. 2). Such erroneous applications of the term can be avoided if we define it in educational terms. Kostelnik says that

...the essence of DAP can be expressed as taking into account everything we know about how children develop and learn, and matching that to the content and strategies planned for them in early childhood programs. (p. 3)

According to Bredekamp (1987) developmental appropriateness is comprised of two dimensions: age appropriateness and individual appropriateness. Age appropriateness refers to the natural and predictable progression or change that occurs in all domains of development (physical, emotional, social, and cognitive). Individual appropriateness takes into account the unique characteristics of each child with respect to background, developmental level, learning style, etc. For a practice to be ‘developmentally appropriate,’ it must take into account what is known about the “age” and individual characteristics of the child. Developmentally delayed children are, by definition, collectively and individually unique from the majority of their age group, thus they pose a special challenge to ensuring that practices are individually appropriate since their ages and developmental levels do not match. Applying the DAP guidelines to this population is discussed below.

Part one of the 91 page DAP document gives the official NAEYC position statement on Developmentally Appropriate Practice in programs serving children from birth to age eight and “Guidelines” for developmentally appropriate practices. While recognition is made that each group

within this age range has different needs (infants and toddlers, preschoolers, primary school children), these guidelines are considered by the NAEYC to be applicable to all children from birth to age eight. The DAP guidelines are divided into the following sections: curriculum, adult-child interaction, relations between the home and program, and developmental evaluation of children (Bredekamp, 1987; Wolery, 1996). (For a complete listing of the DAP guidelines see Appendix A.)

Subsequent parts of the document (Parts 2 through 8) address working with specific age ranges (birth to age 3, 3-year-olds, 4- and 5-year-olds, 5- through 8-year-olds). It is the purpose of these later parts to demonstrate how the guidelines can be utilized by providing lists of "Appropriate Practices" and the comparable "Inappropriate Practices." For example, it states that an appropriate practice for 4- and 5-year-olds involves "interactions and activities...designed to develop children's self-esteem and positive feelings toward learning" (p. 54). The comparable Inappropriate Practice is one in which "children's worth is measured by how well they conform to rigid expectations and perform on standardized tests" (p. 54).

Developmentally Delayed Children and the DAP Guidelines

When a child's development and chronological ages are not on par, the concept of "age appropriateness" cannot be readily applied. In other words, since the DAP guidelines were created with normally developing children in mind, there is debate as to the applicability of these guidelines for children who are developmentally delayed. Wolery & Bredekamp (1994) cite various authors who promote the use of the DAP guidelines with developmentally delayed children in the manner in which they are presently stated. Others (e.g., Bredekamp, 1993; Carta, Atwater, Schwartz, & McConnell, 1993; Wolery, Strain, & Baily, 1992) argue that the DAP guidelines can be utilized with

this special population, but adaptations may be needed. Wolery & Bredekamp (1994) conclude that, in the end, any appropriate practices are child specific whether they are adaptations of the DAP guidelines or not. It is the "...goals and outcomes [that] become the standard against which to judge the suitability, appropriateness, and effectiveness of practice" (pp. 337). In other words, since the goals and outcomes for developmentally delayed children are written on an individual basis, it is these goals and outcomes that must be evaluated as appropriate or inappropriate for this particular child, regardless of how the goals and outcomes were created.

DAP and Curriculum

The intended application of this document to curriculum development is elaborated and clarified in a position statement by the NAEYC in conjunction with the National Association of Early Childhood Specialists in State Departments of Education (NAECS/SDE, 1991). Here, emphasis is given to the interactive nature of the teaching-learning process. Wolery (1996) offers seven basic principles central to this process.

1. Children learn best when their physical needs are met and they feel psychologically safe.
2. Children construct knowledge.
3. Children learn through social interaction with adults and other children.
4. Children's learning reflects a recurring cycle that begins in awareness, and moves to exploration, to inquiry, and finally to utilization.
5. Children learn through play.
6. Children's interests and "need to know" motivate learning.

7. Human development and learning are characterized by individual variation.
(p.189)

These principles are intended to be utilized when developing and selecting appropriate curricula. It should be noted that the principles speak to much more than a pre academic orientation to goal setting. They reflect the setting (principle 1), process (principles 2, 3, 4, and 5), motivation (principle 6) and inter-person variation (principle 7). Wolery (1996), citing the work of Rosegrant and Bredekamp, encapsulates the essence of these principles in the following.

The NAEYC and NAECS/SDE guidelines call for meaning-centered, integrated, "mindful" curriculum, but such a curriculum is only achieved if the other perspectives that inform curriculum are activated - child development knowledge, discipline-based knowledge, and knowledge of the individual developmental/learning continuum of each child. The curriculum guidelines therefore require that curriculum not only be meaning centered but that it be age appropriate (reflect knowledge of child development domains), be individually appropriate (based on children's needs, interests, and individual differences), and have intellectual integrity (reflect the knowledge base of the disciplines (p. 189).

DAP and Assessment of Developmentally Delayed Young Children

Assessment is promoted by the NAEYC and NAECS/SDE (1991) as a tool for guiding instructional plans, identifying developmentally delayed children, program accountability and evaluation (Wolery, 1996). The NAEYC & NAECS/SDE position statement on curriculum and

assessment points out that the purpose of assessment is threefold: planning instruction, screening and diagnosis, and program evaluation. The guidelines promote assessment through observing children in natural contexts, relying on teacher judgement, and minimizing the use of standardized tests (Wolery et. al, 1994). As was pointed out in the previous paper of this folio, current trends in assessment of developmentally delayed young children also call for assessment to be done in natural settings (eg. homes) with input from parents/teachers (Baily & Wolery, 1989; Wolery et al, 1994). Thus, although not written specifically for application to assessment of this population, the NAEYC guidelines also reflect these current trends in assessment of developmentally delayed young children.

Nonetheless, there are differences in the assessment of children with and without disabilities (Wolery et. al, 1994). Developmentally delayed young children are treated differently in that they are more frequently assessed, their parents typically participate to a greater degree, more professionals from more disciplines are involved, and they are usually offered the utilization of an Individual Education Plan (IEP). How educators who follow the general DAP guidelines cope with these additional factors when assessing developmentally delayed young children remains to be investigated: Will more frequent assessments be carried out? Will parent participation be solicited/tolerated? Will other relevant professionals be consulted? Will IEPs be utilized? Answering these questions in future research will provide further insight as to the applicability of the DAP guidelines when assessing developmentally delayed children.

DAP and Families

The DAP guidelines were written with a daycare center/ regular school setting in mind rather than a home or one-to-one special education setting. Thus, parent and family participation is referred

to only within a context of sharing in the decision making process regarding children's care and education, and in the "...sharing of developmental information about children as they pass from one level or program to another" (p.12).

A new edition of DAP titled Developmentally Appropriate Practice in Early Childhood Programs (Bredekamp & Copple, 1997) claims to "better reflect ...the significant role of families in early childhood education ... [and the] applicability of the principles to children with disabilities and other special learning and developmental needs" (p. vi). The new document also claims to better incorporate the "importance of meaningful and contextually relevant curriculum... [and the] necessity of assessment practices that are authentic and meaningful for children and parents" (p. vi). Because this document is recent, its actual effectiveness in addressing the above listed areas of early intervention is yet to be determined. The extent of its usage is also yet to be determined, especially with special populations.

In summary, the DAP guidelines were written with a group setting in mind and no comparable document which specifically addressed the one on one setting of parent and child in the home has been found. Nevertheless, as Wolery and Bredekamp (1994) pointed out earlier, since all early intervention practices, regardless of origin, must stand on their own merit, it is a valid exercise to examine the applicability of documents, such as the DAP guidelines, to the one-to-one setting of the home environment. The fact that the DAP guidelines were not written for a one-on-one setting does not mean they do not have applicability to that setting. By substituting the word "parents" for "teachers" or "adults" it might be argued that at least some of the guidelines are indeed applicable. As an example, the 6th guideline under the heading Curriculum would read "[parents] provide a variety of activities and materials; [parents] increase the difficulty, complexity, and challenge of an

activity as children are involved with it and as children develop understanding and skills" (p. 5).

Division for Early Childhood Recommended Practices

A second document relevant to early intervention with developmentally delayed young children and their families is the DEC Recommended Practices: Indicators of Quality in Programs for Infants and Young Children With Special Needs and Their Families (1993). This document is the product of the 1991 Task Force on Recommended Practices created by the Division for Early Childhood (DEC) of the Council for Exceptional Children.

As the name of the document implies, the mandate was to create and articulate practice recommendations regarding early childhood special education. Like the DAP guidelines, the DEC statement of recommended practices was also created in an effort to provide a frame of reference which could be utilized when creating or evaluating early childhood education programs. It is aimed at a specific population, infants and young children with special needs and their families, in contrast to the general population of young children which was considered when the DAP guidelines were constructed.

Overview

The 139 page DEC document contains more than 400 recommendations which are presented in 14 sections, each with a preamble presenting a rationale for the utilization of the recommended practices. Every "Recommended Practice," before being labeled as such, had to meet certain specified criteria. It had to be: research based or value-based; family centered; multi cultural in emphasis ; applicable across disciplines; developmentally/chronologically age appropriate; and

normalized (Odom & McLean, 1993). The 14 sections are: Assessment, Family participation, Individual Family Support Plans and Individual Education Plans, Service Delivery Models, General Curriculum and Intervention Strategies, Interventions to Promote Cognitive Skills, Interventions to Promote Communication Skills, Interventions to Promote Social Skills and Emotional Development, Interventions to Promote Adaptive Behavior Skills, Interventions to Promote Motor Skills, Transition, Personnel Competence, Program Evaluation, and Early Intervention with Children who are Gifted. Within each section is found a rationale and discussion of the principles related to the topic, followed by a listing of the specific recommended practices.

Citing the works of DeStefano, Howe, Horn, and Smith (1991), Hanson and Lynch (1989), and McDonnell and Hardman (1988), Odom and McLean (1993) point out that many authors and some states have utilized clinical experience to create lists of practices which are held to be of value when working with developmentally delayed young children. While it is acknowledged that this is an important first step, Odom and McLean offer that the DEC recommended practices are necessary at a national level to enable families, experts, and other practitioners to identify and validate what are the best special education practices when providing services to young children and their families. They further state that the recommended practices contained in this document

...may be useful in several ways. Professionals may use them to examine the practices that they currently employ in their programs. Individuals starting early intervention or early childhood special education programs may use these indicators as a guide for selecting practices for their program. Also, family members may use the indicators ...as a "consumer" guide for selecting a program for their child with special needs." (p. 2)

Analysis and Comparison with DAP Guidelines

The critical dimensions of early intervention derived in paper one of this folio and outlined by the DAP guidelines as the categories of major concern when working with young children, namely, curriculum, assessment, and family participation, will now be examined from the point of view of the DEC recommended practices. Within each area, the perspectives of the two documents are also compared. (It should be noted that the DAP guidelines separate curriculum into "Curriculum" and "Adult-Child Interaction." This second focus outlines aspects of curriculum delivery and, as such, is included under the general heading of Curriculum in the following section.)

Curriculum

In the DEC recommended practices document, curriculum is described as including "...content (i.e., behaviors, skills, abilities, and patterns of interacting) that is taught, ...methods for identifying the content for each individual, ...[and] methods of teaching the identified content to each individual" (p.50-51). The recommended practices in the curriculum section are divided into four subsets. The first subset addresses the outcomes of the curriculum and intervention strategies. This subset states, for example, that the intervention must result in:

- "GC4. Increased ability to function/participate in diverse and less restrictive environments [and allow for]
- GC6. Supported or partial participation in routines/activities when independent performance is not possible." (p. 58)

The other three subsets of recommendations regarding curriculum and intervention strategies address development and selection of intervention strategies, adjustments of previously devised interventions strategies, and ensuring that the curricular and intervention strategies are effective. (For a complete list of the 31 recommended practices for this section see Appendix B.)

It should be noted that there are other sections of the DEC recommended practices that are also relevant to the notion of curriculum. Each of these sections give recommendations regarding interventions to promote cognitive skills, communication skills, social skills and emotional development, adaptive behavior skills, and motor skills. Because these sections are aimed at fostering skills, they too can fall under the general umbrella of curriculum. Space does not permit further discussion of these sections individually.

Curriculum and Developmentally Delayed Children: DAP Compared to DEC

Since they were written primarily for the general population of young children, the DAP guidelines regarding curriculum are stated in terms of general principles. They are not intervention oriented for children with special needs but are statements about how normal children typically learn and develop, accompanied by outlined practices that reflect these processes. By contrast, the DEC Recommended Practices are suggestions for specific procedures which are intervention oriented. The DEC practices are to be followed when actively encouraging the development of behaviors, skills, and abilities that have not yet fully developed. Thus, while the DAP guidelines can, in this author's opinion, contribute to curriculum development for these children, the DEC Recommended Practices are more appropriate. The DEC practices address the needs of individual children: "Curriculum and intervention strategies are modified and adjusted as needed and in a timely manner based upon ...the

changing needs of individual infants/children and their families, [and the] ...observed and documented performance of infants/children” (p. 59).

Assessment

The DEC document promotes assessment as a multifaceted and multipurpose procedure that provides a basis for appropriate early intervention. The document asserts that

...when used properly, assessment can help to detect child needs and environmental circumstances that may create problems; to identify child strengths and weaknesses so that appropriate programs can be planned; to identify special family circumstances and needs that may assist in planning for progress; to keep track of changes in child behavior and accomplishments and family needs; and to estimate the effectiveness of teaching, therapy, and other efforts. (p.11)

The document also states that the assessment tools and specific procedures to be utilized will vary with the purpose of the assessment.

The DEC recommended practices regarding assessment are divided into three subsets: “Preassessment Activities;” “Procedures for Determining Eligibility, Program Placement, Program Planning and Monitoring;” and lastly, “Assessment Reports.” Preassessment activities focus on working with families to determine and outline the assessment process, identifying individuals to participate and making explicit goals to be achieved via the assessment. For example, the DEC recommended practice A3 states that “professionals and families identify the questions and concerns that will drive the choice of assessment materials and procedures” (p. 17).

The second subset, Procedures for Determining Eligibility, Program Placement, Program

Planning and Monitoring, recommends practices to be followed when actually carrying out the assessment. Included are recommendations for such activities as gathering information from multiple sources (item A6) and maintaining confidentiality (item A17).

The last subset of recommendations in this section, **Assessment Reports**, addresses the issue of reporting the results of the assessment. The recommended practices offered in this section emphasize making the assessment report practical and readily applicable to the issues of programming. Furthermore, this subset recommends that the report offer both strengths and weaknesses and include statements of the assessment's limitations (A21 and A22). (See Appendix B for a complete list of the 24 recommended practices regarding assessment.)

Assessment of Developmentally Delayed Children: DAP Compared to DEC

As stated earlier in this paper, it is this author's opinion that the DAP guidelines are consistent with current trends in the assessment of developmentally delayed children (outlined in paper one, this folio). That is, even though the guidelines do not address this population directly, they are nonetheless applicable. On the other hand, the DEC recommended guidelines, with a focus on early intervention, address topics of special relevance to this population including increased frequency of assessment, high levels of involvement by parents, and assessment for IEP purposes (Wolery et al., 1994). Because such topics are encountered to a greater degree by professionals working with developmentally delayed children, the DEC document is deemed an especially useful tool for such professionals. It is this author's opinion that all professionals responsible for assessment of developmentally delayed children should become familiar with the relevant assessment principles in both documents, noting that the DEC recommended practices are particularly relevant because

they address topics especially pertinent to assessment of developmentally delayed children.

Family Participation

The DEC recommended practices are intended to promote family participation as paramount, both in terms of decision making for their own children and policy making in general. The parental role is one of full partnership with professionals in all aspects of early intervention. Parents are deemed to have an equal role in all aspects of the program from policy making to program evaluation. Collaboration and the building of positive relationships between parents and professionals that are based on a mutual respect are stated as being a necessary solid foundation on which to build a successful early intervention program.

The recommended practices addressing family participation are divided into nine categories: "Program advising/policy making;" "Staff hiring, training, evaluation;" "Family-to-Family support;" "Intervention;" "Interagency collaboration-Meetings, evaluation, implementation;" "Legislative issues;" "Advocacy;" "Procedural safeguard development;" and "Leadership training opportunities for parents." One of the recommended practices regarding family participation states, for example, that "family concerns, priorities, and preferred resources have priority in determination of the instructional setting" (p. 27). Another recommended practice asserts that "families [are to be the ones to] determine the pace of service delivery" (p. 27). (See Appendix B for a complete list of all fifty recommendations.)

Family Participation and Developmentally Delayed Children: DAP Compared to DEC

The DAP guidelines emphasize the value of having parents participate in the education of

their young children. Such an emphasis is demonstrated by directing early childhood educators to "...maintain frequent contact with [and] ...share child development knowledge, insights and resources as part of regular communication ...with family members" (p. 12). This terminology is somewhat arms-length in that it advocates that parents be kept informed and contacted regularly. By contrast, the DEC recommendations recommend an ongoing complete partnership in which parents and professionals both fully participate in the early intervention process. The DEC view is not surprising given that developmentally delayed children tend to require more one-on-one services. It is logical that parents of developmentally delayed children will generally be encouraged to work with professionals on a more frequent basis. It is appropriate that the DEC, since it specifically serves this population, emphasizes to a greater degree the partnership between relevant professionals and parents.

Home Based Services

Another related area addressed by the DEC recommended practices but not discussed in the DAP guidelines is home-based intervention. If families are to be more involved in nurturing the development of their children, as is the modern trend in the field of early intervention with developmentally delayed children (Kotliarenco, Fuentes, Mendez, 1990; Seitz & Provence, 1991; Shriver, Kramer, & Garnett, 1993; Winton, 1996; paper one, this folio), it is logical to deliver services in the home environment.

The DEC document discusses home based services in a section entitled "Service Delivery Models." This section emphasizes, among other things, that service delivery be in the "least restrictive environment, [and] ...family-centered" (p.40-41). There are four recommended practices

regarding the home-based service delivery model. It is recommended that

- staff base the nature, delivery, and scope of intervention upon activities of daily living (e.g., bathing, feeding, play, bedtime, etc.).
- intervention include all family members (family members being defined by the family) who wish to be involved.
- the level of intensity and range of services match the level of need by the family.
- staff base their communication with family members upon principles of mutual respect, caring and sensitivity. (p. 47-48)

Furthermore, the DEC recommended practices state that "programs [are to] employ clinic-based services only when they are identified as the least restrictive option" (p. 48).

Conclusions

Based on the documents reviewed here, it can be concluded that, when working with developmentally delayed children, each practice must be scrutinized on its own merit. It is the responsibility of those involved in working with these children to ensure that each individual practice is appropriate for the specific child. Because the DDAP guidelines were written with "normally" developing children in mind, few practices relate to a one-on-one setting. This is not surprising since the guidelines were written with a preschool or daycare classroom setting in mind. For example, when discussing four- and 5-year-Olds, the DAP guidelines refer to a ratio of 20 children with 2 adults (p. 57). While individual appropriateness is stated as paramount (Bredenkamp, 1987), the practicality of expecting appropriate curriculum development for developmentally delayed individuals, if only these guidelines are applied to the process, is questionable. It could be argued that

by applying the principles of age appropriateness and individual appropriateness as advocated by the DAP guidelines, to the process of early intervention with developmentally delayed young children, the efficacy of interventions can be enhanced. In other words, even though the DAP guidelines were not written with developmentally delayed children in a one-on-one setting in mind, it is this author's opinion that professionals working with parents and children in such a setting would do well to consider them - especially given the very limited number of comprehensive documents designed to guide program development for young children.

Another point relates to the DAP guidelines statement that "early childhood teachers must work in partnership with families and communicate regularly [emphasis added] with children's parents" (p.12). While this statement promotes the involvement of parents in early childhood education programs, its wording reflects an expectation that parents will not play a major role on an ongoing basis. Instead, they will be informed and consulted regarding the developmental progress of their children. Such an apparent expectation may not be in the best interest of the child (Guralnick & Bennett, 1987; Kassebaum, 1994; Mitchell & Brown, 1991; paper one, this folio).

Lastly, professionals who are responsible for early intervention with developmentally delayed children must first be well versed in general early childhood development. From such a vantage point, individual children with developmental delays can be more fully understood and any early intervention strategies are more likely to be successful. Thus, in the end, the DAP guidelines and the DEC recommended practices may not be adversaries. Because the DEC practices target a narrower population, they may be viewed as extensions of the broader based DAP guidelines. The DAP guidelines are not deemed to be contrary to the principles for working with developmentally delayed children. The DEC more specifically addresses appropriate practices for this specific subset of the

general population of children and professionals working with this population would do well to examine both documents closely and incorporate their usage in practice.

**Issues Around a Regional Approach to In Home Services for the
Developmentally Delayed Preschooler**

It is critical to intervene early in the life of children who are developmentally delayed if they are to be provided with the tools necessary to develop to their full potential. There have been numerous studies which have demonstrated the advantages of actively stimulating a delayed child's development (Berrueta-Clemment, Schweinhart, Barnett, Epstein, & Weikart, 1984; Gersten, Darch, & Gleason, 1988; Schweinhart, Barnes, & Weikart, 1993; Wasik & Slavin, 1993.) and there is a consensus that early intervention with developmentally delayed preschoolers is effective (Marfo, Brown, Gallant, Smyth, Corbett, & McLennon, 1988, Ramey and Ramey, 1992). Since developmental lags are often evidenced in a child's preschool years, stimulation of a child's developmental progress should begin in the first years of life (Marfo et al., 1988). Based on this premise, many early intervention services have emerged with the goal of encouraging the progress of developmentally delayed young children.

This paper looks at the delivery of services to developmentally delayed young children in the province of Newfoundland, Canada. Newfoundland is, in part, an island province with a population of 544,400 people (Statistics Canada, 1998) distributed over its 405,720 km². While there are some urban centres, much of the population lives in small, rural communities spread over a land mass that would rank 4th in size if it was a U.S. state behind Alaska, Texas, and California (Government of Newfoundland and Labrador, 1999). Newfoundland has a limited economy in that it has an unemployment rate of 17.9% and an employment rate of only 44.4% (Statistics Canada, 1998)

The Direct Home Services Program (DHSP) is a part of the Department of Health and Community Services, Government of Newfoundland and Labrador and was established in 1975 with a primary goal of helping families of developmentally delayed preschoolers utilize early intervention techniques aimed at encouraging these children to reach their full potential before entering

Kindergarten (Browne, Corbett, Gallant, & Thompson, 1985). Much has been learned regarding the most appropriate methods of early intervention since the DHSP was first established.

With a view to utilizing more effective strategies, the service delivery model adopted by the province was recently modified. The original approach to intervention utilized by the DHSP was, at the client level, highly directed by the Child Management Specialist (CMS), the title given to the DHSP field worker. The CMS assessed the child and choose the skills to be targeted (taught or enhanced). The new model advocates a partnership approach between the parent(s) and the CMS, with the parent(s) being heavily involved in deciding what skills are to be taught next.

This paper will compare the methods traditionally utilized by the DHSP to deliver service with the newly adopted modified approach. Attention is paid to the degree to which this new approach reflects currently promoted practices in early intervention with developmentally delayed preschoolers. The results of this investigation are important in that they will aid in determining the probable effectiveness of the new approach to early intervention adopted by the DHSP.

Background and Nature of DHSP Services in Newfoundland

The DHSP was piloted in 1975 as a publicly funded early intervention program with a mandate to provide early intervention services to developmentally delayed young children. The goal of the program was to maximize the potential of the children before school entry. The program was modelled after the Portage Project in Wisconsin, created in the early 1970's (Sturmey, 1991; paper one, this folio). The program proposes that intervention should occur as early as possible in the life of a child and that the home is the most natural environment in which to deliver intervention services - utilizing the parents as teachers. Since 1975, the DHSP has grown to become a permanent

publically funded program with more than 30 staff serving approximately 300 children and their families (Marfo et al. 1988).

The Service

Children within the DHSP identified as potentially having a developmental delay are typically referred by parents, public health nurses, doctors, or other professionals concerned with the development of the child: On the first visit the CMS explains the program and, with parent participation, proceeds to assess the child using the Alpern-Boll Developmental Profile (Alpern, & Boll, 1972). This assessment tool establishes the child's present developmental level in each of five areas: Social, Self-help, Language, Motor, Cognition. These scores are then compared to the child's chronological age. In order for a child to qualify for the services of the Program, a developmental lag of six months or more in two developmental areas or of one full year or more in one developmental area must exist.

If a child qualifies, and the parent agrees to take advantage of the service, the CMS proceeds to complete a full developmental checklist, the Portage Guide to Early Education (Bluma, Shearer, Frohman, & Hilliard, 1976). This checklist outlines many behaviors and skills in the order of typical developmental sequence in each of the five developmental areas assessed by the Alpern-Boll Developmental Profile. Once the checklist is completed, it is utilized to determine the order in which skills will be taught to the child. That is, the Checklist is used to determine the skills that the child does not yet possess but are expected to develop next. The skills that are targeted to be learned are then written in behavioral format as target statements or goals: who will do what to what degree of success. This information is worded on a target sheet with a chart provided to record whether or not the child performed the targeted skill successfully during each trial. An example of a targeted

statement or goal might be “Amy will draw a circle nine out of ten times with hand on wrist guidance.” The CMS then demonstrates to the parent the manner in which the skill is to be taught. There is an emphasis on the giving of praise or some other reward. (In the above example, the CMS would place his or her hand on Amy’s wrist and help her to draw a circle). The parent then imitates what has been modelled, with the CMS giving corrective feedback if necessary. Three to five skills are targeted each week.

During each subsequent weekly visit the CMS reviews the chart on which the parent has recorded the child’s progress in the learning of the skills. If the child was successful in demonstrating the skill, the CMS will modify the target statement or devise a new one. For instance, in the above example the next target statement might be “Amy will draw a circle nine times out of ten with verbal guidance only.” The Alpern-Boll Developmental Profile is readministered periodically (every six months) to monitor developmental progress.

Reflections upon the Program

Considering that this program is province-wide and publicly funded, it is a concern that there have been few reviews of its impact, especially within the past decade. In 1988, Marfo, Brown, Gallant, Smyth, Corbett, & McLennon set out to empirically analyse the DHSP and its effectiveness. Their study had a six-fold purpose:

- A. to examine parents’ early experiences pertaining to the detection of the child’s problem, awareness about and access to early intervention services, and contact with support groups;
- B. to analyze parental perceptions about, and satisfaction with, the early

intervention program – including perceptions about the intervention worker’s competence.

- C. to appraise parental expectations about the child’s future, and to examine the relationship between such expectations and the perceived severity of the child’s handicap or delay;
- D. to obtain a measure of parent-child interactive play, both in terms of a variety of activities and the frequency with which interactive play occurs;
- E. to ascertain the program’s effectiveness relative to child developmental progress; and
- F. to examine the role that family ecological variables play in the intervention process – paying attention to parental, family, ecological, and intervention variables that appear to be associated with (1) child developmental progress and (2) parental satisfaction with intervention. (p. 5)

While a discussion of all these goals is beyond the scope of this paper, it is important to note that five out of six of these statements of purpose deal with parental or family variables. Given what we now know about the importance of family participation in such programs (Bredekamp, 1987; DEC, 1993; Guralnick & Bennett, 1987; Kassebaum, 1994; Kotliarenco, Fuentes, & Mendez, 1990; Mitchell & Brown, 1991; Seitz & Province, 1990; Shriver, Kramer, & Garnett, 1993; Winton, 1996; paper one, this folio) it is not surprising that Marfo et al found that, among other things, there was a need for greater parental support and control within the early intervention program. The recommendation was made that the program “place a greater emphasis on preparing parents to become independent of the program as quickly as possible” (p. 76). Thus, as Templeman-Barnes

(1996) points out, Marfo et al promoted utilization of a family system approach to intervention as opposed to a purely child-centered approach (Templeman-Barnes, 1996).

In an unpublished Master's Thesis, McLennon (1993) surveyed the parents of children served by the DHSP to determine the existence of interrelationships between variables possibly affecting their children's developmental progress. She concluded that

it is clear from this study that relationships exist between the child's developmental level, parent expectations, program satisfaction and knowledge gained, the nature of play between parent and child, parent's education, the families [sic] resources and the overall quality of the home environment.

In delivering an early intervention program that recognizes these relationships, the focus of such programs must be sufficiently broad to incorporate initiatives toward the provision of services to families that extend beyond specific skill teaching. These services should include the provision of educational and financial support to parents directed at improving the quality of the home environment. (p. 115).

Thus, she points out that, while the program is meeting a specific need and is regarded highly by participating families, it has to be broader based and must address more than just specific skill teaching. It must also address the variables of family ecology. In other words, it must become more family-focussed rather than just child-focussed.

The one goal of the Marfo et al study that did not address parental or family variables was the investigation of the effectiveness of the program in enhancing child developmental progress. The results indicated that, on average, children served by the program had a progress rate that was 83%

of the normal rate of development. However there was a significant negative correlation between the amount of time a child was served by the DHSP and the amount of developmental gain achieved. This was interpreted as indicating that the most substantial developmental gains were made early in the intervention program, which is what one would expect since "...there is more room to demonstrate the impact of intervention in the absence of prior programming than there is once intervention has started and has begun to increase developmental competence" (p. 54). Marfo et al also indicate that, since the DHSP serves children from birth to six years of age, the results may suggest that the

...intervention activities and strategies are best suited to younger and beginning recipients, such that the intervention becomes less responsive to the developmental needs of children beyond either a certain level of developmental competence or a certain level of involvement with programming. Thus there may be a need to critically examine programme content and instructional strategies to ascertain the extent to which they remain developmentally appropriate, challenging, or enhancing for the entire range of ages covered. (P. 55)

The New Approach

Thus, as noted above, both the study of Marfo et al and that of McLennon state that parents must play a greater role in the early intervention process. To this end, in 1996 the DHSP created a document titled Early Intervention Plan: 3rd Draft Procedural Statement which was subsequently adopted as a revised official policy. This eleven-page statement outlines a shift from a child-centered

to a family-centered orientation to early intervention.

Whereas the original model of the DHSP was directed by the CMS and the Portage Checklist, the new approach proposes a partnership model in which the parents are viewed as equal partners in deciding on the skills to be taught next. In the new document, the Alpern-Boll Developmental Profile and the Portage Checklist are still stated as being "...essential resources a Child Management Specialist will use to assist families to discuss concerns and identify developmental goals" (p. 4). The new approach states that it "...upholds the three major goals of the Direct Home Services Program: i) to improve childhood outcomes, ii) to enhance parenting abilities and overall family well-being, iii) to promote community inclusion" (p. 1).

In essence, the new approach views a partnership model as a means to empower families by making them full partners in decision making regarding the skills to be taught to their children. Dunst, Trivette, and Deal (1988) are cited as stating that it is important to help parents appreciate that positive changes can result from their own decisions and actions, thus leaving them with a sense of control over their own lives and the lives of their children.

The Procedural Statement put forth by the DHSP goes on to describe the components of the Early Intervention Plan or EIP (the name given to the set of skills to be learned by the child and the manner in which they will be presented or taught). The three components of the plan are "Goals," "Things to Do," and "Review." The "Goals" are statements regarding projected skills and competencies to be acquired in an area of concern to the parent and CMS, usually achievable within 30 days. "Things to Do" are the means by which in which the Goals will be achieved. Resources to be utilized can be included along with supports and activities. (Also included may be usage of the traditional Target Sheets outlined in the previous section.) The "Review" section of the EIP

specifies a date on which to review the child's progress. A determination is made whether or not the Goal has been achieved and/or if some other action is necessary (eg. modification, postponement, or abandonment). The original EIP remains in the home of the child while a copy is retained by the CMS for file-keeping purposes.

Comparison of Traditional and New Approaches

The prior and current approaches to early intervention utilized by the Direct Home Services Program and the province of Newfoundland are examined below within the context of the three components offered as critical to early intervention programs with developmentally delayed preschoolers papers one and two of this folio. These components are curriculum, assessment, and parental involvement.

Curriculum

Individualized curricula are necessary for young children with developmental delays (Bailey & Wolery, 1989; Carta, 1995; DEC, 1993; Safer & Hamilton, 1993; Seitz & Provenca, 1990; Turbville, Turnbull, Garland, & Lee, 1993; paper one, this folio). Such individualization requires task analysis of more complex skills, adaptation of teaching materials, utilization of various types of individually appropriate prompts, and the identification of motivational factors especially applicable to the individual child (Carta, 1995). Individualization is at the heart of the DHSP and is evident in the program's setup. The CMS goes to individual homes and works with individual children and their families to help create an ever changing and evolving curriculum tailored to the

present developmental levels of the children.

Under the previous program model of the DHSP, curricula was developed relying basically, only on the Portage Checklist. Thus, children were taught what was deemed to be a standard and comprehensive set of typical and necessary skills. It was apparently assumed that a child who acquired all the skills outlined in the Portage Checklist, would have developed to an appropriate level. Thus, teaching these skills to developmentally delayed children would be a method of preparing them for school entry and equipping them with the skills found in their normally developing same-aged peers. While few would agree that this procedure would eliminate developmental delays in all children, such a procedure did provide an individually administered, yet shared curriculum to all children served by the DHSP. Children were placed on this curriculum beginning at individualized starting points and progressed at their own paces supported by individualized teaching strategies.

As stated above, the original program outlined the curriculum for a CMS to follow when attempting to enhance the development of young children. Such a rigid approach to curriculum development reflects the major assumption that the Portage Checklist curriculum would meet the needs of all children. This, of course, was shown not to be the case in the studies of Marfo. et. al (1988) and McLennon (1993). Both studies stated that the curriculum development process initially used by the DHSP was too rigid with respect to specific skill teaching. It did not address differing needs of individual children and it did not address family ecological variables which are important in any early intervention program seeking to provide children and their families with lifelong skills. With greater direction being given by the parents in the new DHSP approach it is possible that the child's progress through the curriculum will also enhance parent competence, confidence, and

assertiveness. In other words, while provision is still made to incorporate usage of such tools as the Portage Checklist, children are placed within a family and social context.

Both the old and new approaches focus on skill teaching. The difference is increased parent decision-making around prioritizing the order in which specific skills will be taught and how they will be taught. The new approach does not appear to address in any new direct way the necessity of increasing the quality of the home environment or the educational concerns of the parents. Both the Marfo et al.(1988) and the McLennon (1993) studies state that such concerns should be addressed if the effectiveness of the DHSP is to be increased. Nonetheless, with the increased parental control over the process put forward by the new approach, it is more likely that the concerns of Marfo et al. and McLennon will be addressed. It should be noted that some may argue that these unaddressed aspects of the family environment are outside the mandate of the DHSP and should remain as such since they are the mandates of other personnel (eg, Human Resources workers and/or social workers). However, since the CMSs visits the same homes every week, they may be in a better position to detect the needs of the home, especially as those needs relate to the development of the children.

While, to date, no data is available on the new approach, it would appear to be moving toward what is being advocated in the literature, namely a curriculum which, with parental input, capitalizes on what children are ready and eager to learn. The degree to which this curriculum is effective remains to be studied.

Assessment

Assessment is not addressed to any great degree in the new DHSP Procedural Statement.

This is somewhat disappointing given the importance of assessment in the early intervention process (Neisworth, 1993; Notari, Slentz, & Bricker, 1991). Perhaps it is because the traditional approach to assessment utilized by the DHSP is in keeping with the current trends of assessment of developmentally delayed young children (papers one and two, this folio). Indeed, it would appear that, by the very nature of the program, the DHSP has been utilizing processes of child needs assessment for many years that are now being promoted as most desirable procedures. These are assessment of children in their natural setting (home), with input from parents, repeated frequently, and aimed at monitoring developmental progress of the children (Bagnato & Neisworth, 1991; Bredekamp, 1987; DEC, 1993; Neisworth, 1993; Wolery, 1996; Wolery, Werts, & Holcombe, 1994).

The Alpern-Boll Developmental Profile (1972) continues to be the primary tool utilized in assessing the young children. The tool requires input from parents. It yields children's developmental levels in five development domains: cognition, communication, socialization, self-help, and motor (Marfo et al., 1988). It yields overall scores in each of the domains but does not yield specific strengths or weaknesses within each domain. Thus, while it does provide inter-domain comparisons, it does not yield specific skills which a child has acquired that can be utilized to encourage development of other specific skills (DEC, 1993; Neisworth, 1993).

With parents taking a more active role in determining curriculum, their knowledge of their children's strengths and interests can be capitalized upon when encouraging further development of skills and in the development of the child specific curricula. However, parents may not realize the amount of knowledge they hold about their children's likes, dislikes, abilities, and inabilities and that this knowledge is foundational in any the early intervention process. Whether or not these insights

are utilized in programming and curricula design depends upon the ability of the CMS to help parents recognize that they have this knowledge to help them use it.

Parental Involvement

Under the original approach, a CMS would occasionally develop target sheets for skills not in the Portage Checklist but based on suggestions made by the parents (eg., specific to a child's unique environment or condition). This, however, was not the routine method of selecting skills to be taught. Typically, the CMS would utilize the Portage Checklist to determine what was to be taught next. While the new approach subscribes to a partnership model, its language suggests that direction is still being given primarily by the CMS. For example, one part of the document states that "families can be asked ... *is this something you wish to work on? If not, then what is important to you?*" (DHSP Procedural Statement, 1996, p. 4). On the other hand, another part of the document states that the "Alpern-Boll Developmental Profile, the Portage Checklist, and other assessments and curriculums [sic] are essential resources a Child Management Specialist will use to assist families [to] discuss concerns and identify developmental goals" (p. 4). An apparent implication is that parents can take more control over the process but they will still be expected to go along with what the CMS would have suggested under the original model. In the end, the degree of parent involvement will depend on the manner in which the new process is implemented by the CMS. If the parents are provided with the information from the Portage Checklist but are given complete latitude to focus on things not covered in the Checklist, as is suggested by the new document, parental control will truly exist. While it may be difficult for a CMS to utilize the same tools (Alpern-Boll Developmental Profile and Portage Checklist) and at the same time yield more

control over the intervention process to the parents, a more discussion oriented approach to deciding what skills a child needs to develop next will allow for greater parental input. It is this author's opinion that it is whether or not the CMS has the desire or skills to help the parents fully discuss such issues that may be the determining factor in the success of the new approach.

The above noted concern should not overshadow the positive aspects of the new early intervention program. The fact that parents are explicitly stated to be full partners in the process should create a sense of respect for the parental role by the CMS's. Department policy and directives should encourage this. The parents themselves should also come to greater respect their roles when they are acknowledged as full partners in the early intervention process. Such an acknowledgement should increase parental enthusiasm for the program especially since they, in general, are likely to want to be heavily involved (Able-Boone, Goodwin, Sandall, Gordon, & Martin, 1992).

It is expected that, by parents taking an increased ownership of the program goals and achievements, they will be empowered and "...able to more adequately cope with the ongoing demands of supporting children with developmental challenges" (DHSP Procedural Statement, 1996, p. 2) after they are graduated from the DHSP upon school entry. Such empowerment, while not directly stated as a goal in the Procedural Statement, can help achieve one of the recommendations made by Marfo et al. (1988) who suggested that any intervention should prepare "...parents to become independent of the programme as quickly as possible" (p. 76).

Conclusions

The new partnership approach to early intervention adopted by the DHSP is an important step in providing service to developmentally delayed young children and their families and is, in this

author's opinion, an improvement over the traditional approach. Some basic positive aspects of the old approach are maintained (eg., serving children and parents in their home setting) while incorporating new knowledge of effective early intervention (eg., increased parental control over the process).

The fact that parents are viewed as full partners in the ongoing process of deciding which behaviors, skills, and patterns of interacting will be taught/addressed next is intended to give parents a sense of empowerment and control of the process. It is this author's opinion that by encouraging parents to take such ownership of the early intervention program, there is an increase likelihood that parents will be more inclined to put in the necessary time and dedication required to make the interventions maximally effective, resulting in more developmental gains being achieved. Furthermore, since parents are now heavily involved in the formation and modification of developmental goals, they are more likely to gain the self confidence and competence to independently modify the goals when necessary as opposed to waiting for the next weekly visit, as in the traditional approach. Thus, the effectiveness of the program may be increased in this manner as well. Through this process, some parents' skills may develop to such a point that they can carry on the intervention without the ongoing weekly participations of the CMS. Some developmentally delayed children may thereby be provided with a lifelong interventionists, their parents. This outcome would allow the CMS to move on and service other families which have been waitlisted (Marfo et al., 1988), making the DHSP more efficient.

The DHSP's modified approach to early intervention should also have a positive effect in curriculum terms. Whereas, under the old approach, the Portage Checklist was used to determine skills to be taught, now the priorities of the parents take precedent, incorporating the use of the

Checklist when appropriate. This can lead to a truly individualized curriculum that speaks to the children's specific needs yet maintains developmental appropriateness (Bredekamp, 1987, Kostilnik, 1993) through incorporation of the items on the Portage Checklist.

Future Research

As Marfo & Cook (1991) point out, there is a need for research into early intervention services for developmentally delayed young children which is aimed at specifying in detail, the best intervention procedures. The characteristics of the population should be studied so that specific intervention procedures can be deduced. This paper has examined the potential impact of the new approach to early intervention adopted by the DHSP in 1996. Whether or not its potential impact is realized depends on many factors which require study in future research. Future studies need to determine if:

- A. the parents participate to the extent anticipated?
- B. there is a change in the types of skills and behaviors that are taught?
- C. parents take ownership of the process or will they become more dependent on the CMS?
- D. parents become independent of the program more quickly?
- E. ecological variables of the family are addressed?
- F. developmental progress of the children is enhanced?

In essence then, it remains to be seen whether or not the new approach will actually better equip parents to "...cope with the ongoing demands of supporting children with developmental challenges"

(p. 2) after they have left the program as the DHSP Procedural Statement claims they will be able to do.

Also, within parent and child models, such as the one outlined here, the interactions between the parties (parents, children, and CMS) provide foundation for all other aspects of the program. In such programs, “the elements of emotional support, of interpretation of behavior, and of guidance and counselling are integral to the process” (Seitz & Provence, 1990, p. 404). There is no comment in either the original or revised DHSP documents regarding the incorporation of these elements into the program. Does CMS training and capabilities reflect these elements or is additional inservice required? In other words, is it within the mandate and ability of the CMS to emotionally support, guide and counsel parents, as well as interpret their behavior?

Finally, as noted earlier, Marfo et al (1988) found that while children served by the original DHSP made significant developmental progress, there was also a significant negative correlation between the amount of time children were served by the program and overall developmental progress. How will the new approach impact the rate of child developmental progress? Will the rate of developmental gains be sustained for a longer period of time?

To answer these questions it will be necessary to reexamine the DHSP utilizing methods similar to those used by Marfo et al. (1988) and McLennon (1993). It is only then that the actual (as opposed to potential) effectiveness of the modified DHSP can be concluded.

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Appendix A

Guidelines for Developmentally Appropriate Practice in Programs Serving Children from Birth to Age 8

These are the DAP guidelines as written by the National Association for the Education of Young Children (1987) (p. 3-13) written verbatim with commentaries omitted.

I. Curriculum

- A. Developmentally appropriate curriculum provides for all areas of a child's development: physical, emotional, social, and cognitive through an integrated approach.
- B. Appropriate curriculum planning is based on teachers' observations and recordings of each child's special interests and developmental progress.
- C. Curriculum planning emphasizes learning as an interactive process. Teachers prepare the environment for children to learn through active exploration and interaction with adults, other children, and materials.
- D. Learning activities and materials should be concrete, real, and relevant to the lives of young children.
- E. Programs provide for a wider range of developmental interests and abilities than the chronological age range of the group would suggest. Adults are prepared to meet the needs of children who exhibit unusual interests and skills outside the normal developmental age range.
- F. Teachers provide a variety of activities and materials; teachers increase the difficulty, complexity, and challenge of an activity as children are involved with it and as children develop understanding and skills.
- G. Adults provide opportunities for children to choose from among a variety of activities, materials, and equipment; and time to explore through active involvement. Adults facilitate children's engagement with materials and activities and extend the child's learning by asking questions or making suggestions that stimulate children's thinking.
- H. Multicultural and nonsexist experiences, materials and equipment should be provided for children of all ages.
- I. Adults provide a balance for rest and active movement for children throughout the program day.
- J. Outdoor experiences should be provided for children of all ages.

II. Adult-Child Interaction

- A. Adults respond quickly and directly to children's needs, desires, and messages and adapt their responses to children's differing styles and abilities.
- B. Adults provide many varied opportunities for children to communicate.
- C. Adults facilitate a child's successful completion of tasks by providing support, focused attention, physical proximity, and verbal encouragement. Adults recognize that children learn from trial and error and that children's misconceptions reflect their developing thoughts.
- D. Teachers are alert to signs of undue stress in children's behavior, and aware of appropriate stress-reducing activities and techniques.
- E. Adults facilitate the development of self-esteem by respecting, accepting, and comforting children, regardless of the child's behavior.
- F. Adults facilitate the development of self-control in children.
- G. Adults are responsible for all children under their supervision at all times and plan for increasing independence as children acquire skills.

III. Relations between home and program.

- A. Parents have both the right and the responsibility to share in decisions about their children's care and education. Parents should be encouraged to observe and participate. Teachers are responsible for establishing and maintaining frequent contacts with families.
- B. Teachers share child development knowledge, insights and resources as part of regular communication and conferences with family members.
- C. Teachers, parents, agencies, programs, and consultants who may have educational responsibility for the child at different times should, with family participation, share developmental information about children as they pass from one level or program to another

IV. Developmental Evaluation of Children

- A. Decisions that have a major impact on children such as enrollment, retention, or placement are not made on the basis of a single developmental assessment or screening device but consider other relevant information, particularly observations by teachers and parents. Developmental assessment of children's progress and achievements is used to adapt curriculum to match the developmental needs of children, to communicate with the child's family, and to evaluate the program's effectiveness.

- B. Developmental assessments and observations are used to identify children who have special needs and/or who are at risk and plan appropriate curriculum for them.
- C. Developmental expectations based on standardized measurements and norms should compare any child or group of children only to normative information that is not only age-matched, but also gender-, culture-, and socioeconomically appropriate.
- D. In public schools, there should be a developmentally appropriate placement for every child of legal entry age.

Appendix B

DEC Recommended Practices General Curriculum and Intervention Strategies

Curriculum and intervention strategies are derived from and based on: (a) the individual abilities and needs of infants/children, families' preferences, and the cultural context; (b) information obtained from comprehensive assessment process and (c) the philosophy of the program.

Curriculum and intervention strategies result in:

- GC1. No harm to infants/children, families or their relationship.
- GC2. Active engagement of infants/children with objects, people and events.
- GC3. Increased initiative, independence, and autonomy by infants/children across domains.
- GC4. Increased ability to function/participate in diverse and less restrictive environments.
- GC5. Independent (unprompted) performance of age-appropriate, pro-social behaviors, skills and interaction patterns.
- GC6. Supported or partial participation in routines/activities when independent performance is not possible.
- GC7. Acquisition (initial learning) of important values, behaviors, skills, and interaction patterns across domains.
- GC8. Generalization, adaptability, application, and utilization of important behaviors, skills and interaction patterns across relevant contexts.
- GC9. Efficient learning (most rapid acquisition) of important goals (behaviors, skills, patterns of interaction).

Curriculum and intervention strategies are developed, selected, and implemented in a manner which:

- GC10. Supports and promotes family values and participation.
- GC11. Is responsive to infants'/children's interests, preferences, motivation, interactional styles, developmental status, learning histories, cultural variables, and levels of participation.
- GC12. Integrates information and strategies from different disciplines.

- GC13. Structures learning activities in all relevant environments.
- GC14. Establishes a balance between child- and adult-initiated/directed activities.
- GC15. Integrates skills from various domains within routine activities in the classroom (i.e., is activity-based).
- GC16. Promotes acquisition (initial learning), fluency (proficiency), maintenance retention), and generalization (application, utilization) of important goals (behaviors, skills and patterns of interaction).
- GC17. Is most natural, normalized and/or least intrusive, given that the benefits to individual infants/children's learning are equal.
- GC18. Is most parsimonious (simpler/simplest) given that the benefits to individual infants/children's learning are equal.

Curriculum and intervention strategies are modified and adjusted as needed and in a timely manner based upon:

- GC19. The changing needs of individual infants/children and their families.
- GC20. Observed and documented performance of infants/children.
- GC21. Concerns, opinions, and needs expressed by the family.

Effective curriculum and intervention strategies include:

- GC22. Use of materials that have multiple purposes, are adaptable, are varied, and reflect functional skills.
- GC23. Milieu strategies (i.e., incidental teaching, mand-model procedure, modeling and naturalistic time delay) that involve brief interactions between adults and children.
- GC24. Peer-mediated strategies (e.g., social interaction training, peer initiation training, peer modeling, peer prompting and reinforcement).
- GC25. Adult imitation of infants/children's play and other behavior.
- GC26. Elaboration of infants/children's behavior by providing models, re-stating the child's vocalizations, suggesting alternatives, and open-ended adult questions.
- GC27. Prompting strategies (e.g., constant and progressive time delay, system of least prompts, simultaneous prompting, most to least prompting, graduated guidance) that provide

learning opportunities, adult assistance, reinforcement for correct performance, and fading prompt assistance.

- GC28. Differential reinforcement that provides children with feedback for desired performance and withholding feedback (e.g., planned ignoring) when desired performance does not occur.
- GC29. Responsive shaping that provides positive reinforcement for progressively more complex performance.
- GC30. Self-management procedures that involve teaching children to identify appropriate behavior, evaluate their own performance, direct their performance verbally, and select reinforcement based on an evaluation of their performance.
- GC31. Correspondence training, which involves providing children with positive reinforcement for matching what they say they will do (Say-do-strategy) or have done (Do-say-strategy) with their actual performance.

DEC Recommended Practices Assessment

Assessment in early intervention refers to the systematic collection of information about children, families, and environments to assist in making decisions regarding identification, screening, eligibility, program planning, monitoring, and evaluation.

Preassessment Activities

- A1. Professionals contact families and share information about the assessment process.
- A2. Professionals solicit and review existing information from families and agencies.
- A3. Professionals and families identify the questions and concerns that will drive the choice of assessment materials and procedures.
- A4. Professionals and families identify pertinent agencies, team members, and team approaches to be employed (e.g., inter-, multi-, transdisciplinary approach).
- A5. Professionals and families identify a mode of teaching that fits individual children's needs and families' desires to collaborate.

Procedures for Determining Eligibility, Program Placement, Program Planning and Monitoring

- A6. Professionals gather information from multiple sources (e.g., families, other professionals, paraprofessionals, and previous service providers) and use multiple measures (e.g., norm-referenced, interviews, etc).
- A7. Professionals gather information on multiple occasions.
- A8. Team members discuss qualitative and quantitative information and negotiate consensus in a collaborative decision-making process.
- A9. Team members select assessment instruments and procedures that have been field-tested with children similar to those assessed for the purposes intended.
- A10. Assessment approaches and instruments re culturally appropriate and nonbiased.
- A11. Professionals employ individualized, developmentally compatible assessment procedures and materials that capitalize on children's interests, interactions, and communication styles.
- A12. Materials and procedures, or their adaptations, accommodate the child's sensory and

responsive capacities.

- A13. Professionals assess strengths as well as problems across developmental or functional areas.
- A14. Measures and procedures facilitate education and treatment (i.e., intervention or curriculum objectives) rather than only diagnosis and classification.
- A15. Measures are sensitive to child and family change.
- A16. Professionals assess not only skill acquisition, but also fluency, generalization, and quality of progress.
- A17. Professionals maintain confidentiality and discretion when sharing information.
- A18. Curriculum-based assessment procedures are the foundation or "mutual language" for team assessment.

Assessment Reports

- A19. Professionals report assessment results in a manner that is immediately useful for planning program goals and objectives.
- A20. Professional report assessment results so that they are understandable to and useful for families.
- A21. Professionals report strengths as well as priorities for prompting optimal development.
- A22. Professionals report limitations of assessments (e.g., questions of rapport, cultural bias, and sensory/response requirements).
- A23. Reports contain findings and interpretations regarding the interrelatedness of developmental areas (e.g., how the child's limitations have affected development; how the child has learned to compensate).
- A24. Professionals organize reports by developmental/functional domains or concerns rather than by assessment device.

DEC Recommended Practices Family Participation

Families are equal members in and can take part in all aspects of early intervention systems. This includes participation in all aspects of their child's care and all levels of decision making.

Program Advising/Policy Making

- FP1. Family members receive payment for their expertise, time and expenses while participating on councils, committees, and other aspects of early intervention policy/planning.
- FP2. Meetings occur at times and locations that allow family members to participate.
- FP3. Programs specify in writing, in an understandable manner, the roles of family members in program advising.
- FP4. Program advising and policy making activities include members from more than one family.
- FP5. Family members participate in the entire policy and procedures development process (from conceptualization through public comment and revision).
- FP6. Families have the opportunity to develop policy making skills if they choose through mentoring and or training.
- FP7. When it is necessary to use terminology (words or phrases) that are not familiar to family members, professionals explain the meaning of the terms in family-friendly language and provide written descriptions.

Staff Hiring, Training, Evaluation

- FP8. Family members participate in and, if they choose, are paid for: developing job descriptions, advertising for positions, reviewing applications, interviewing candidates, selecting person for the job, conducting orientation activities for new staff, and evaluating staff.
- FP9. Families may participate in a variety of roles in staff training: planner, needs assessor, deliverer, participant and evaluator.

- FP10. Programs involve family members in gathering evaluative data and input from other families.
- FP11. Evaluative feedback from and decision making with family members produces program changes, development and expansion.
- FP12. Family members help develop evaluation tools.
- FP13. Family members have a role in the process of formulating conclusions and implications of evaluation data and in disseminating the results.

Family-to-Family Support

- FP15. Family support services (respite, advocacy, parent-to-parent networking) are available as requested by the family.
- FP16. Program Personnel/staff introduce new families to other families in the program.
- FP17. Family to family support services create an atmosphere which supports exchange of information among families.
- FP18. Linkages to natural community supports for families are built and encouraged.
- FP19. Support groups can include extended family members and other family support network members if a family chooses.

Intervention

- FP20. Natural community settings are developed and accessible as an option for early intervention.
- FP21. Family concerns, priorities, and preferred resources have priority in the determination of the instructional setting.
- FP22. Program staff provide information to families about using intervention strategies across settings.
- FP23. Families receive information when they ask for it in a way that is meaningful to them.
- FP24. Families determine the pace of service delivery (e.g., to change intensity of child and family participation as needed to meet the family's needs).
- FP25. Dreams and visions for the future expressed by families are encouraged and supported.

- FP26. Families can initiate program monitoring activities if they choose.
- FP27. Program staff explain methods of monitoring progress to families and offer opinions for modes of monitoring.
- FP28. Families are asked to monitor progress and satisfaction to the extent they feel comfortable.
- FP29. Essential supports such as child care and transportation are available so that families can participate in all levels of early intervention.

Interagency Collaboration-Meetings, Evaluation, Implementation

- FP30. Families are included on all interagency teams and groups, throughout all phases of the effort.
- FP31. Families are provided the opportunity and support to develop a handbook which helps them and subsequent parents through the "agency process".
- FP32. Families are asked on an ongoing and systematic basis to provide feedback on the interagency collaboration process.
- FP33. Agencies, with the help of families, develop one form which will be acceptable to all for intake, the IFSP/IEP, and monitoring.
- FP34. Public awareness efforts are targeted at typical community settings to expand their availability to families of children with disabilities.

Legislative Issues

- FP35. A mechanism exists to inform families about the importance of legislative involvement.
- FP36. Families receive information in language they prefer and understand about the laws that support services to their children and themselves.
- FP37. Professionals respect family members' decisions to become involved, or not involved, in political action.

Advocacy

- FP38. Advocacy groups to support regular early childhood services include the concerns of children with special needs and their families.

- FP39. Families participate equally (with professionals) in determining issues that are targeted for advocacy efforts by a program.
- FP40. Professionals or agencies inform family members when they can not advocate for issues identified by families because of professional conflict.
- FP41. Programs provide families with information on their State's advocacy services and organizations.
- FP42. Veteran families support new families as they begin advocacy efforts.

Procedural Safeguard Development

- FP43. Programs have clearly specified procedures for recourse/redress of grievances.
- FP44. A mediator, independent from the program, participates in grievance procedures if they cannot be settled by the family members and the program.
- FP45. Families may make decisions to use alternative services, programs, and methods unless they jeopardize their child's live.

Leadership Training Opportunities for Parents

- FP46. Intervention programs coordinate training opportunities for families with parent training groups funded to provide such training as well as with other community training opportunities.
- FP47. Families receive parent-directed newsletters and literature.
- FP48. Programs provide support, financially if necessary, for families to attend local, state and national level meetings.
- FP49. The program provides families with options for training opportunities, times and methods from which to choose.
- FP50. State lead agencies and ICCs fund an annual, formal leadership training for family members.



