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Home-Based Services

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The most common method of service delivery for infants and toddlers is home visits, yet little research has been conducted on effective ways of providing services this way. Some preschoolers are also served through home visits. The term “home visits” actually usually refers to a broader context: A “home visit” could occur in a community setting with the family, not just in the home. Furthermore, many “home visitors” make visits to children in their child care or preschool settings, often without the parents. Most of this chapter will refer to home visits provided to the family in their home, but every principle applies regardless of the actual location. Visits to children in group care settings are covered elsewhere in this book.

Tiffany Macdonald looks forward to Tuesday afternoons. That’s when Tamara comes and talks to her about little James Macdonald’s development, health, behavior, and so on. This is the one time in the week when someone (a) has a lot of suggestions for her and (b) really cares what life is like for her—Tiffany. Tamara knows a little bit about a lot of things. Maybe she knows a lot about some things, but they talk about so much, Tiffany isn’t sure. The week between Tamara’s visits can sometimes seem long, but life is busy with James. Anyway, Tamara says that soon they’ll have e-mail at the early intervention program and that will help. Tiffany sometimes calls Tamara, but she hates to bother her too much because she knows Tamara sees lots of other families. When Tamara doesn’t know something, she arranges to come out with someone else from the early intervention team who

knows specifics about whatever the topic was. For example, one time Tiffany had a question about James’s stiffening up when he got upset. Tamara said she didn’t know if it meant anything important but that her friend Patti at the office would know. A couple of weeks later, she and Patti, who identified herself as a physical therapist, came out together. Patti played with James and gave Tiffany (and Tamara) some information about muscle tone and some suggestions. The following week, Tiffany and Tamara talked about what Patti had said, which helped Tiffany remember the information. Tamara reassured her that if things changed or they needed to talk to Patti again, that could be arranged.

Susannah Goldman had a very “involved” (to coin a favorite term in early intervention) IFSP. She had to work on head control, babbling, playing with toys, tracking people when they moved, sucking on the bottle more strongly, playing very simply back-and-forth games, avoiding colds, swallowing.... It seemed to Hannah, her mother, that the list was endless—so many things to try to fit into a busy day. Even though Hannah and Susannah were home every day, life was unbelievably hectic. Four days a week, someone from the early intervention program came to house. At first, Hannah was delighted and surprised that all these experts were available to come to the house. She had a physical therapist, an occupational therapist, a “speech therapist,” and, well, Monica. Monica had two titles, according to the mounds of paperwork Susannah had piled up in a corner of her den: service coordinator and early interventionist. It was hard to classify her. She was like a

counselor, a social worker, a friend, and a teacher. She was the one who talked to her most about James's playing with toys, but she also spent a lot of time talking about (yet more!) services, and just listening. After 6 months of all these people coming to her house at separate times, Hannah had come to two realizations. First, there were some things they all talked about—like Susannah's head control. Then, there were other things that one person knew about and the others acted like they didn't know anything about—like swallowing. But Hannah was expected to learn about all these. She wondered if parents had to learn all this stuff, how come some professionals couldn't. But she was now feeling guilty about resenting all these people invading her house and her life. She knew she should still be grateful for all this help, but having to get ready 4 days a week for someone to come into the house was getting old. It was also just a drain dealing with four people about such intense issues as Susannah's development. She actually was relieved every time one of them had to cancel the visit for some reason. Sometimes she wondered how stupid they thought she was, that she should need so many people to tell her what to do with Susannah. But again she suppressed those bad thoughts.

The above two scenarios are composites from real stories heard over and over again. Often, professionals and families are unaware that home visits can be done differently from the way they are done in their home communities. Early intervention is a relatively small and insular field, with many professionals learning home visit practices on the job. So practices are perpetuated on the basis of tradition, sometimes in the absence of theory or evidence. This chapter will concentrate on "support-based" home visits, because it is a model incorporating recommended practices, acknowledging research on children's learning opportunities, and responding to theory about children's learning and development. It should be read in conjunction with the consultation chapter.

Home Visits Defined

At the simplest level, home visits simply define a location. Yet this is misleading for two reasons:

1. It is possible and probably ineffective to take a multidisciplinary, clinic-based approach and relocate it to the home; and
2. "Home visits" do not happen only in homes.

In this section, various models, the purpose of home visits, common activities, appropriate candidates, and intensity are introduced. These topics will be elaborated upon later in the chapter.

Models and Effectiveness

The effectiveness of home visits has been questioned, especially in the fields of regular early childhood and public health (e.g., Goodson, Layzer, St. Pierre, Bernstein, & Lopez, 2000). On the other hand, in the field of early intervention, home visits are accepted with scant attention to research. This section highlights some models and types of home visits as well as the efficacy literature.

Models

This chapter is concerned only with ongoing, intervention-focused home visits, not sporadic visits to families by professionals or home visits strictly for data collection. To begin with and to place early intervention home visiting in a wider context, it is worth noting that home visits are used in other disciplines. For example, they are used with the elderly (Roane, Teusink, & Wortham, 2002), with parents who have a history of substance abuse (e.g., Project STAR, Kaminski, Stormshak, Good, & Goodman, 2002), and with parents considered at risk for abusing their children (MacMillan, 2000). Outside early intervention, nurses are probably the most common home visitors (e.g., Butz, Lears, & O'Neil, 1998; Korfmacher, Kitzman, & Olds, 1998; Landy, Peters, Arnold, Allen, Brookes, & Jewell, 1998; Macmillan, 2000; Olds & Korfmacher, 1998).

Many people involved in home visiting in early intervention might be unaware that *home health visiting* (HHV), typically by nurses, is an old and widespread service in northern Europe. This service, typically involving newborn visits and several subsequent visits in the first 3 years of life, began in the mid-19th century in Great Britain. It is one example of broad-based supports to families that differentiate the European tradition from the American tradition. Unfortunately, the research base for European HHV is sparse. Denmark, which has had systematic home health visiting since 1937, has provided numerous visits to all newborns in the first year of life and then continued visits to children with special needs until they are 6 or 7 years old. One study found that 10% of the children had special needs, but only 4% were continued owing to abuse or neglect (Christensen, 1999). An essential feature of the HHV model is connecting families with various social welfare programs, which is similar to the service coordination concept in the U.S. This feature reflects the broad definition of “health” in this model, which resulted from the discovery of the social pressures on young families. Therefore, a goal of the British and Danish HHV services, for example, is the empowerment of the parents.

In Britain, home health visitors are assigned general population “patches,” most typically involving a ratio of 1 visitor to 5,000 people. In this group, there would likely be 200-300 families with children under 5. Therefore, each nurse visits every child in the first year but then selects those for visits after that (Christensen, 1999). With this kind of intensity, HHVs are quite different from the kinds of ongoing home visits needed in Part C; they serve a purpose more akin to designated service coordinators, who are separate from ongoing service providers.

Parent training is often a major purpose for the home visits, and such training programs have been developed for families of children with developmental disabilities (Feldman & Werner, 2002), for

families of children with challenging behavior (e.g., Greene, Kamps, Wyble, & Ellis, 1999; the Fast Track Program, Orrell-Valanete, Pinderhughes, Valente, & Laird, 1999), and for families of children with nonorganic failure to thrive (Feldman, Garrick, & Case, 1997). In addition to the types of children already mentioned, models have been developed for children with autism (e.g., Frameworks for Communication, Chandler, Christie, Newson, & Prevezer, 2002), “disadvantaged families” (Goodson et al., 2000); children exposed to drugs in utero (Butz et al., 1998), and even children who have deliberately poisoned themselves (Harrington et al., 1998).

One of the most widely used programs for children not necessarily with disabilities is the Parents as Teachers program (Pfannenstiel & Seltzer, 1989) the efficacy of which has been tested on different groups, such as Latino families and teen parents (Wagner & Clayton, 1999). According to the Parents as Teachers National Center, evaluations of this program has shown that their parents are more knowledgeable about child-rearing practices, are more confident in their parenting skills, engage in more language- and literacy-promoting behaviors, and are more involved in their children’s schooling. Children at age 3 are more advanced than comparison children in language, problem-solving, and other cognitive abilities, and social development; and they score higher on kindergarten readiness tests and standardized measures in first-fourth grades (Parents as Teachers National Center, 2002).

Some home visiting programs involve the use of paraprofessionals or nonprofessionals. The Deaf Mentor Experimental Project, for example, involved the use of deaf adults as home visitors to children who were deaf or hard of hearing and their families (Watkins, Pittman, & Walden, 1998). Another project involved the use of lay visitors to children diagnosed as failure to thrive (Hutcheson, 1997).

The role of professional Part C home visitors has been explored in one study, in which a child focus, as opposed to a family focus, was found to be most common (McBride & Peterson, 1997). This focus tended to be more common among families who had adequate resources compared to home visits among families who were low in resources. The more caretaking demands there were for the child, the more time home visitors spent observing, as opposed to being actively involved with the child. Although limited in its geography and number, this study suggests what many people in early intervention have observed informally—that home visits tend to resemble a clinic-based, instructional model with a fairly narrow focus on direct intervention with the child. As will be seen later in this chapter, such a model is likely to be ineffective.

Efficacy

Home visits focused on training parents on specific interventions have been shown to be effective (Feldman & Werner, 2002). In a study of interventions to use with 2- and 3-year-olds with autism, home visits were successful after 18 months in showing improvements in the children's language (Chandler et al., 2002). Home visits provided during the preschool years have predicted modest effects as late as 3rd and 6th grade (Bradley & Gilkey, 2002). They have been used to prevent child abuse and neglect with mixed results. In one review, only home visit programs were shown to prevent child physical abuse and neglect, and multicomponent, community-based programs were shown to promote family wellness and prevent a number of negative outcomes for children (Nelson, Laurendeau, & Chamberland, 2001). In an important study, home visits ameliorated the effects of childhood maltreatment on early manifestation of problem behaviors (Eckenrode et al., 2001). Although in this book we discuss home visits for children with disabilities, some of the history of home visiting is based on visits for parents with risk conditions. For example, relation-based intervention with "at-risk mothers"

(Heinicke, Rineman, Ponce, & Guthrie, 2001, p. 431) has been shown to make a significant positive impact during the child's first 2 years of life on the mother's support and on mother-child and child development. Skepticism about home visiting has come from evaluations such as the one on the Comprehensive Child Development Program, a comprehensive, 5-year family support program for low-income children and their families. Home visits by nurses have been used with families who have abused or neglected their children and have been found to decrease the association between maltreatment and early onset problem behaviors (Eckenrode et al., 2001).

What Are They For?

The purposes of home visits are (a) to provide services to the child and family, (b) to do so in a "natural environment," which includes (c) doing so in the family's natural activity settings.

Provide Services

The IFSP or IEP will identify home visits as a method of service delivery or a location. Services are generally identified by the disciplines of the provider (Giangreco, Edelman, Luiselli, & MacFarland, 1997). So physical therapy, for example, is a service and it is defined as activities a physical therapist carries out. Any attention to motor concerns by anyone other than a PT cannot be considered physical therapy. This had led to the first of a number of myths about home visiting.

Myth 1. Only a specialist can attend to specific areas of concern. For example, only a speech-language pathologist can identify language goals and program for language development with the family.

Once the IFSP or IEP lists various services, which, as just stated, often are associated with individual providers, these professionals might then be tempted to make separate home visits (Lamorey & Ryan, 1998). This is especially true if they come from different agencies.

Coordination of services would probably be enhanced if home visits were

considered a service, rather than simply a method of providing, essentially, therapy, special instruction, and service coordination. This might lead to a theoretical conceptualization of “the home visit,” which would stand in contrast to either an atheoretical conceptualization or no conceptualization at all.

Myth 2. More is better. As will be discussed in this chapter and in the consultation chapter, it is not necessarily in the child’s or family’s best interest to load up on the number of home visitors.

Myth 3. Early interventionists can help families only with what they were trained in. Actually, most early interventionists can help families with a vast array of areas (Bruder, Anderson, Schutz, & Caldera, 1991). There are certain functions that can only be carried out by licensed people. In early intervention, those functions might be (a) diagnosis and (b) programming for certain therapeutic techniques (within the fields of OT, PT, SLP, psychology, for example).

Myth 4. Two hours of service a week means the child gets only 2 hours of intervention a week. Service and intervention are not the same thing. Service is what professionals provide, whereas the majority of the intervention the child receives is from his or her caregivers (e.g., family, child care providers). If caregivers can be supported adequately through one comprehensive home visit a week, the child might still receive much intervention from them. If caregivers do not provide much intervention, adding one or two more home visits would probably not change the outcomes. Caregivers are teaching children throughout the day, every day. The challenge of home visits is to channel that teaching towards developmentally useful behaviors.

Myth 5. Home visiting means parent training. (See Myth 6.)

Myth 6. Home visiting doesn’t mean parent training. The truth is that most home visits involve the provision of “informational support” to families, in the sense that they tell families about strategies

that should help the child. This means the home visitor is giving the family information the family can use, which could be considered “training.” If the family does not use it, however, it is questionable training. Nevertheless, sometimes families want to be taught how to do something or want to be taught about something. In these situations, home visitors satisfy the family when they provide the information and follow up to ensure the family has the information they wanted (i.e., evaluates the “training”). In fact, behavioral parent training has been shown to be effective in reducing child behavior problems, disruption to child and family quality of life because of those problems, and stress related to limits on family opportunities (Feldman & Werner, 2002). Furthermore, parent training, not necessarily conducted through home visits, has been effective in changing families’ use of milieu strategies (Hester, Kaiser, Alpert, & Whiteman, 1996; Kaiser, Hancock, & Nietfeld, 2000).

Another option is to infuse “parent training” into the home visits. In this instance, the home visitor is not responding to a family’s request to be taught something. Nor is the home visitor simply providing information. Rather, the home visitor is attempting to influence the family through modeling, games, didactic information, conversation, and so on. This informal “parent training” is often done to “teach” parents about effective ways of talking to and playing with their children. Therefore, home visiting is much more than parent training but it can involve parent training, from a structured form of it to an almost-invisible form of it.

Use Natural Environments

In Part C, developmental services “to the maximum extent appropriate, are provided in natural environments, including the home, and community settings in which children without disabilities participate” (IDEA, 1997, Part C, Sec. 632 [4] [G]). This is somewhat disingenuous because children without disabilities typically do not receive home

visits, yet that is often the first and major step early intervention programs take to comply with the natural-environments provision of the law. It is helpful to understand that this provision follows in the tradition of the “free and appropriate public education” mandates of Part B of IDEA, which is designed to provide inclusive experiences for children with disabilities. In other words, Part C attempts to prevent segregation of infants and toddlers with disabilities. Indeed, the most common reaction of states to this part of the law has been to close down segregated classroom programs and to provide home visits instead. A corollary has been, with some more resistance, to move from clinic-based services to home-based services (Strain, Smith, & McWilliam, 1996). The concept of “natural environments” is not restricted to location, however. Using activity settings for intervention is one example that what happens during home visits is as important as where it happens.

Use Activity Settings

Dunst and Bruder (1999) have defined activity settings, a term they borrowed from the field of community psychology, as follows:

An activity setting is a situation-specific experience, opportunity, or event that involves a child’s interactions with people and the physical environment. An activity setting happens whenever a child finds herself in a particular place or situation where people, materials, and objects in those settings either encourage or discourage the child from doing something.

(http://www.puckett.org/childlearn/L.O._Newsletter_Vol.1,2.htm)

The conceptual framework of these researchers was that a few locations can have more activity settings, which in turn have even more learning opportunities. In family life, therefore, activity settings can include family routines, family rituals, and family celebrations. In community life, they can include family outings, church or religious groups, and sports activities or

events. In this chapter, we will concentrate primarily on family routines.

Routines defined. Routines have been defined primarily as times of the day or family events. They would include all the activity settings and learning opportunities listed in Dunst and Bruder’s (1999) categories. They are not specific times of the day as in 7:00 a.m. Nor are they events that happen in a predetermined or consistent order. They typically consist of such events as breakfast, going in the car, hanging out in the living room, bath time, and so on. They can include fairly frequent or important events outside the home, such as going to the grandmother’s house, going to church, or going to the grocery store. Different families mention different routines, different times when they happen, and different ways of carrying them out.

Home visits are, therefore, a method for providing services in natural environments. This method gives the professional the opportunity to use family routines as the context for the family to teach the child.

What Do You Do During Home Visits?

This chapter will describe in some detail how to conduct support-based home visits. First, though, traditional home visits, which early interventionists are likely to encounter, will be described briefly.

Traditional Home Visits

For years, home visitors have worked with three tools: the toy bag, the developmental checklist, and the handout. In the section called Addressing Concerns, this resource is questioned. Developmental checklists can lead to (a) a deficit model, in which the youngest failures are targeted for; and (b) a notion that items on such checklists are important. The handouts imply that the parent should do home work, that the answers can be found on a professional-provided piece of paper, and that reading is the parent’s natural method of gaining knowledge. All three tools are used because the traditional home visitor has a presumed belief that his or her

contacts with the child are the keys to the child's learning.

An Alternative

An alternative to traditional home visits is support-based home visits, which are described in a later section. In essence, the alternative involves giving families a structure for identifying their routines,

Figure 1). Because many families choose to be home with their infants, home visits are logical. Certainly, children who are not in child care, regardless of age (i.e., including preschoolers), should receive

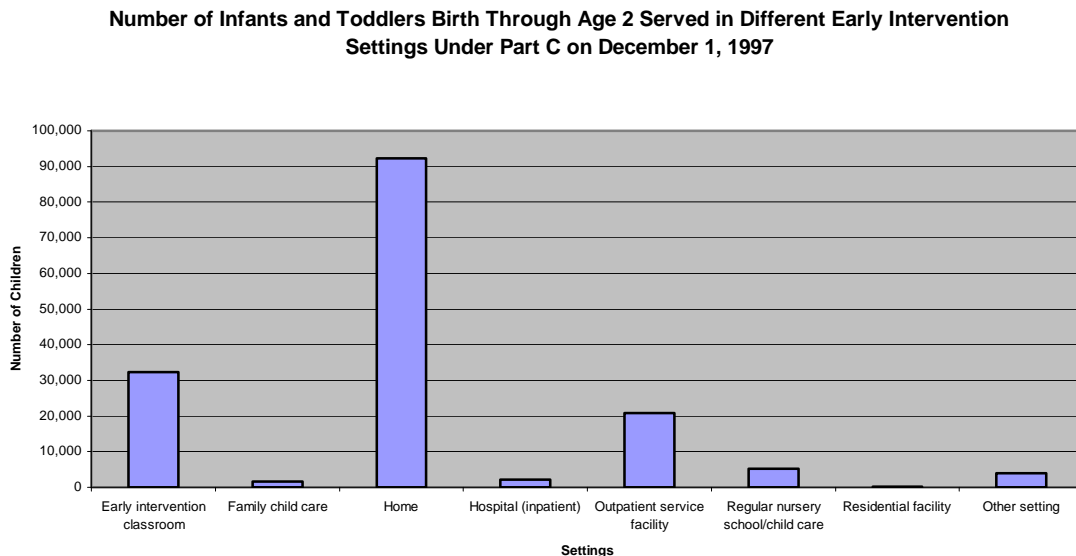
their needs in those routines, and their priorities.

Home visits should concentrate on routines because they are the core of a family's life. They occur frequently and are largely under the family's control.

Who Should Get Home Visits?

The home is the most typical setting for infants and toddlers (see home visits. Some families have family-level issues of such complexity that they equal or even override child-level issues. These families should also probably receive home visits.

Figure 1. Number of infants and toddlers birth through age 2 served in different early intervention settings under Part C on 10/1/97.



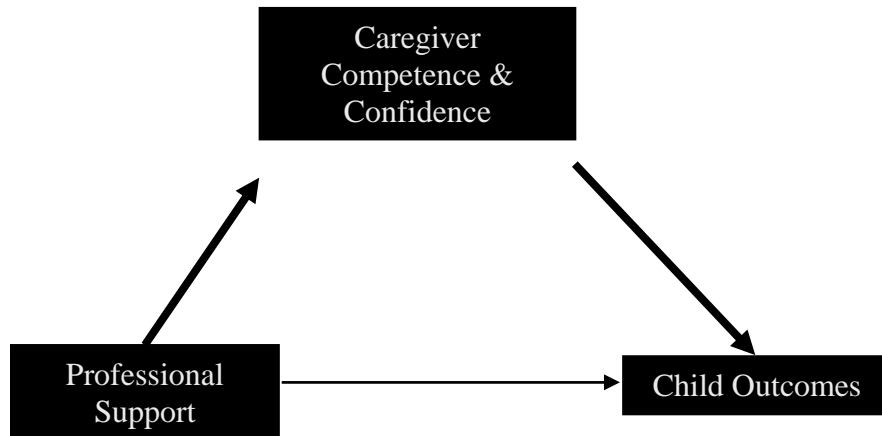
Intensity of visiting both families and child care programs. If the child is in a group care setting, such as a child care program or a preschool, but the family could benefit from home visits, the early intervention or preschool system could be faced with a challenge about the intensity of services. Should such a family receive two visits a week—one for the child at the group care setting and one for the family at home? Although this should not be a problem, owing to the individualization of services, many programs report it as a

funding predicament. Should the family receive one visit a week, alternating between group care consultation and home visits? This level of intensity might be insufficient for either setting. The average intensity of services in Part C is less than 2 hours (Kochanek & Buka, 1998).

How Often?

This discussion of intensity has disclosed what has become the default intensity in early intervention: weekly home visits. Considering the amount of support that can be provided in home visits,

this frequency is probably a reasonable



average across families. Critics of the intensity of Part C services might well be confusing services with intervention. When a family receives less than 2 hours of service, that has nothing to do with the amount of help the child is receiving.

children learn, and (c) the importance of what happens between visits. Some of these points are also made in the consultation chapter.

Who Influences What

Early intervention activities with children can have only a modest effect on developmental trajectories, intelligence, motor control, and other child-level outcomes. These outcomes are notoriously difficult to

change, and seeing a child and family for one or two sessions a week is unlikely to have too much of a direct influence on them. The family accounts for the majority of the variance in these outcomes, both through their nurturing (parenting; e.g., Steelman, Assel, Swank, Smith, & Landry, 2002) and their nature (genes). Early intervention can have considerable impact on nurturing, because the outcomes are confidence and competence. These two outcomes, unlike the child outcomes mentioned earlier, can be influenced significantly by early intervention activities. Adults’ self-assurance and skill can be shaped by support from early

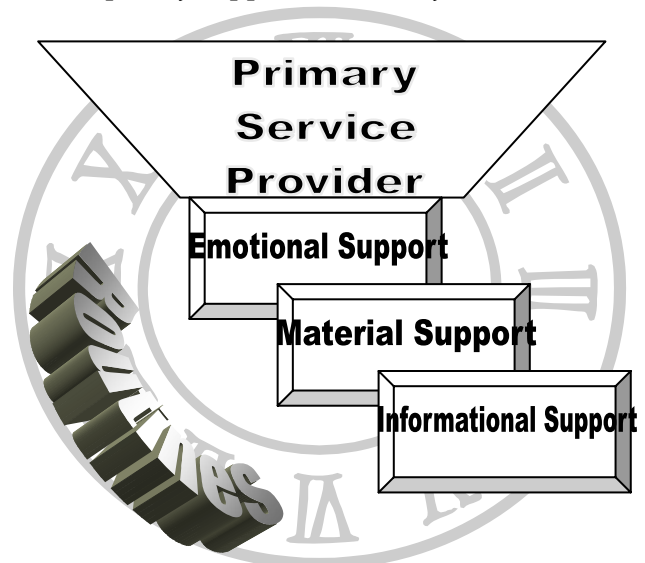
Conceptual Framework

The figure shows a conceptual framework for home visiting. Such a framework is necessary to make clear the distinction between home visits as simply a location issue and home visits as a theory-based method of providing services. The first component is represented by the beveled boxes, which contain the content or “curriculum” of home visits. The second component is represented by the trapezoid (symbolizing a funnel), which indicates a model of service delivery. The third component is represented by the clock in the background, which symbolizes the context of the interventions—routines. Each of the components of the framework is described next.

Establishing a Model

Support-Based Services

This three-part framework has been described as a theoretical approach to home visits (McWilliam & Scott, 2001) that recognizes (a) the potential influences of early intervention activities, (b) how



interventionists. Those family characteristics, in turn, can have much more of an impact on children’s outcomes

than could weekly sessions with a child. Because of who can influence what or whom, therefore, the theoretical approach to home visits should consist of much attention to families' confidence and competence.

How Young Children Learn

Young children learn through repeated interactions with their environments, dispersed over time, not through trials massed into sessions or lessons. Each repeated practice that older children might receive in such situations adds to the child's learning. In young children, practices need to be spaced apart enough for the child to process the information. Furthermore, when the child is taught in the context of naturally occurring stimuli, the child learns to use the behavior in the relevant context. The corollary is teaching language through flash cards versus conversation. The role of the home visitor needs to reflect the reality that children learn throughout the day, whether planned or otherwise. It will emphasize support to the family to be effective teachers, rather than direct intervention with the child.

Between Visits

What happens between home visits is, therefore, critical to children's learning. And what happens between home visits is the child's and family's routines. That is why assessment and intervention planning based on routines is so important for children's learning and development (Bernheimer & Keogh, 1995).

Types of Support

The idea of early intervention as a venture focused on support has been backed in the literature (Dunst, Trivette, & Cross, 1986; Guralnick, 2001; McWilliam & Scott, 2001). Three types of support that encompass the majority of home visit practices are emotional, material, and informational support.

Emotional. The importance of encouraging families is neither surprising nor new (Powell, 1987). Mothers provided the opportunity of a positive, trusting, and

working relationship with a weekly home visitor as well as a mother-infant groups scored higher on measures of their experienced partner and family support than did mothers not getting the support (Heinicke et al., 1999). Children in the intervention group scored higher on a strange-situation task, and their mothers were more responsive to their needs.

Professionals' behavior towards families has been included in a number of conceptualizations of early intervention services, including family-centered practices (e.g., Dunst, Johanson, Trivette, & Hamby, 1991; P. J. McWilliam & Winton, 1991; Turnbull, Turbiville, & Turnbull, in press; Winton & Bailey, 1988), help-giving practices (Dunst, Trivette, Davis, & Cornwell, 1994), and stress-reduction approaches (McCubbin & Patterson, 1987). An example of the kinds of characteristics home visitors use to give emotional support was the finding from a qualitative study of family-centered service providers (McWilliam, Tocci, & Harbin, 1998). The five characteristics they found do not encompass all emotionally supportive practices, but they do constitute a useful framework for organizing this aspect of home visiting. They were positiveness, responsiveness, orientation to the whole family, responsiveness, and sensitivity. These are described in Chapter XXXX, in the section on communication skills.

Material. The second type of support home visitors should be prepared to provide is material support, which is defined as ensuring families have access to the resources they need to accomplish their goals. Resources include equipment, supplies, and financial resources. Some children benefit from equipment so they can be engaged, independent, or social. Home visitors need to make sure families have such equipment. Some families need basic supplies, such as food, shelter, and clothing. They will be unlikely to take advantage of learning opportunities if they are wondering where the next meal is coming from (Maslow, 1943). Home visitors need to make sure families have

access to such supplies. Some families will need financial resources, such as temporary assistance to needy families (TANF); social security income (SSI); nutrition for Women, Children, and Infants (WIC); and so on. Home visitors will need to make sure families eligible for such assistance can gain access to it.

The teacher or therapist providing home visits might think this is far outside his or her area of expertise. They would probably be right, which is why they should develop skills in using human resources, such as Part C service coordinators, social workers, and other “case workers.” In the same way that a social worker might need to call a speech-language pathologist to help with a particularly thorny problem the child was having with language, the speech-language pathologist might need to call a social worker to help the family get SSI.

Informational. The third type of support is providing information to families. In almost every study asking families what more they want from early intervention than they are currently getting, they list information (D’Amato & Yoshida, 1991; Fewell, 1986; Gowen Christy, & Sparling, 1993). There are four topics on which families often want information: the child’s condition or disability, child development (including what the child should be doing at this developmental age and what will come next), resources (including services now and in the future), and what to do with the child. That last topic, hidden away in the list, actually encompasses the majority of what home visitors do. It also is the real meaning of “therapy” and “special instruction” in home visits.

When therapy and special instruction are viewed as informational support, professionals might be more likely

to deliver the service in a way that is consistent with how children learn. For billing and other purposes, providing this information should count as reimbursable therapy or special instruction. When working with infants and preschoolers through home visits, this is how those services should be provided. For practitioners and families who fear that “just providing information” is not what early intervention is about, they can be reassured that it still involves much handling of the child. The three reasons for putting hands on a child are assessment, demonstration, and to show affection. Consequently, the home visitor might still spend most of each home visit handling the child.

When home visitors provide emotional support, material support, and informational support, they address many of the purposes of home-based early intervention

Primary-Service-Provider Model

In addition to support-based services, the use of a primary service provider is likely to result in an efficient, family-centered service that focuses on functional needs (McCormick & Goldman, 1979; Raver, 1991). This model is controversial, mostly because of misunderstanding about how it works. Some aspects of it are addressed in the consultation chapter.

The primary-service-provider (PCP) model is defined as one professional providing weekly support to the family, backed up by a team of other professionals who provide services to the child and family through joint home visits with the primary service provider. The intensity of joint home visits depends on child, family, and PSP needs. The following table deconstructs this definition.

Table 1. Deconstruction of the Definition of the Primary-Service-Provider Model

Term	Explanation
One professional	This professional can be from any discipline. In some programs, all disciplines can have roughly equal caseloads, with some of each

	<p>professional's time devoted to consulting with colleagues. This is a pure form of transdisciplinary service delivery. In other programs, "generalist" disciplines (e.g., early childhood special education, social work) have caseloads, while "specialist" disciplines (e.g., OT, PT, SLP) spend all their time consulting with the generalists. This is a modified form of transdisciplinary service delivery.</p>
Weekly	<p>This is the default intensity level. In the absence of extenuating circumstances, this frequency, for about an hour, would be offered to families.</p>
Support	<p>Support consists of emotionally supportive professional behavior, ensuring families have access to material resources, and ensuring families have access to information, including what to do with their child.</p>
Other professionals	<p>Most of the support from other professionals will come from those identified on the IFSP and IEP as providing services.</p>
Services	<p>This is how a child would receive a particular service if the PSP could not, because of licensing restrictions, provide that services him- or herself. The non-PSP specialist (a) assesses the child from the perspective of that discipline, if necessary; (b) makes recommendations from the perspective of that discipline about meeting family priorities (this becomes the "treatment plan" for billing purposes); (c) monitors the family's implementation of the plan (in a manner similar to monitoring implementation by an aide or assistant for older children); and (d) evaluates, with the family, the outcomes of the "treatment plan" (i.e., the intervention suggestions). These four activities are consistent with common definitions, by professional associations, of service delivery in early intervention.</p>
Joint home visits	<p>The method for the non-PSP to have direct contact with the child and family is through the a home visit made jointly with the PSP. This allows the PSP, the family, and the consultant to exchange information, observe each other, and be in synchrony with each other. Joint home visits should occur as needed but not so often that the PSP does not make many home visits alone. If that becomes</p>

	the case, the wrong person was probably assigned to be the PSP. The rule of thumb is that the PSP makes a joint home visit about every fourth home visit.
Intensity	Many factors contribute to the decision about how often joint home visits should be made. It is generally assumed that the more complex the child's and family's needs are, the more often other professionals will need to help the PSP. This should, however, be weighed against some other factors. First, the competence and confidence of the PSP should play a major role in the decision. An experienced, knowledgeable PSP requires less consultation than does a novice PSP. Second, the total number of professionals serving the child and family should play a role in the decision. If four specialists on the IFSP or IEP, and all four visit monthly, the PSP is never making individual home visits. And individual home visits by the PSP are the bread and butter of this model. Third, the stage of an intervention should help determine how often joint visits occur. If a new intervention has just been put in place or if the child has recently accomplished a new skill, the team might decide the specialist should be involved more often. If an intervention is coasting along, with the child's making steady progress, the team might decide that less intensity is required.

Table 1 has encapsulated the main points about the PSP also known as transdisciplinary model. Concerns about the model are as follows.

Concern 1. The model involves practicing without a license.

The PSP is not practicing anything other than what he or she is qualified to practice. Supporting a family to carry out a licensed or registered specialist's program does not require a license. It is what a neighbor might do. If an OT is the PSP, then much of his or her work would constitute practicing OT. In a modified-transdisciplinary model, however, where a generalist is the PSP, he or she is emphatically not *practicing* outside the area of individual expertise.

Concern 2. It is unethical for practitioners to see children so infrequently.

There is no rubric for calculating the appropriate intensity of services, so there are no ethical guidelines. If someone on the team thinks a family is being seen too infrequently, that person should call a team meeting to resolve the issue. If a specialist insists that, ethically, he or she needs to see a family much more frequently than the rest of the team agrees upon, this might reflect this person's discomfort with the model. If he or she has a real concern about intensity, the team needs to provide an opportunity for the case to be made.

Concern 3. It is unethical for practitioners to turn over the

monitoring of the program to someone else.

Again, this concern usually reflects a practitioner's discomfort with the transdisciplinary approach. The monitoring of the program is still the specialist's responsibility. What the PSP is doing is supporting the family in carrying out the interventions, which is different from monitoring the "treatment program," as defined by national and state guidelines. Again, the analogy is how aides or assistants are used. Although they have frequent contact with the recipient of services (usually to provide therapy), the responsibility for monitoring the program rest with the licensed professional.

Concern 4. PSPs are unqualified to support families in carrying out specialized programs.

This concern hinges on the definition of support. In this context, PSPs support families by reminding them what the specialist said, encouraging them in their implementation of the interventions, and listening to their concerns and triumphs. Experienced PSPs might suggest different ways to make the implementation of the program easier for the family, which is a sign of true partnership. Inexperienced PSPs might not be confident about any change to what the specialist has recommended. For all concerned, the more the PSP can contribute, the better.

Concern 5. One cannot be reimbursed for this model.

This model is reimbursable because it is the therapists' contact time with families that third-party payers will pay for. The work of the PSP might or might not be reimbursable under any specific plan. Medicaid, for example, might cover some of those activities under "targeted case management." Rules for reimbursement of the PSP vary enormously. Clearly, however, someone pays for home visits by generalists. In pure-transdisciplinary situations, where a therapist functions as the PSP, most of every visit can be reimbursed as therapy time. In some

systems, the PSP has to bill for the time spent "providing therapy" and for the time spent in "targeted case management" separately. In general, services using the model are reimbursable.

Concern 6. Families want more specialists, not fewer.

It is true that families believe that *more is better*, when it comes to services, especially therapies (McWilliam, Young, & Harville, 1996). The critical question is why families believe this (McWilliam et al., 1998). First, professionals might teach this notion, by suggesting during planning meetings that separate needs require separate services. Second, families might think that it is the direct time that professionals spend with the child that causes positive change. In other words, they might believe that intervention for the child occurs during the home visit more than between it. When families are introduced to the more-is-better idea early, it is not surprising that they would endorse it. But when families are introduced to the PSP model, their expectations are different.

These concerns about the PSP model reflect the fact that it is innovative and a challenge to tradition, especially traditions so closely tied to the "therapy culture." The controversy around the service delivery model is accompanied by another controversy in early intervention generally, but one that is most often effected in home visits.

The Controversy of Parent Education

A recent clarion call for returning to the notion of parent education in early intervention (Mahoney et al., 1999) has been met with much protest (Dunst, 1999; Winton, Sloop, & Rodriguez, 1999). The main arguments have been that (a) early intervention was founded on the idea of teaching parents what to do with their children, (b) parents' interactions with their children are predictive of later functioning, and professionals can teach parents the most effect interaction styles, and (c) the field has wandered too far and

that a focus on parent education will achieve the most impact.

Are Aides Necessary?

In some parts of the country, aides are used to provide home visits, often because of shortages of licensed professionals. Such aides might be licensed physical therapy aides, certified occupational therapy aides, speech-language aides, or education aides. It is possible that they are used because the team believes that direct contact by a noncaregiver, even just weekly, can make a difference (which is unlikely). Although there are bound to be situations where an aide is useful, in home visits this is not likely to be true. The PSP should be a well-qualified individual, usually someone with the highest professional qualifications in his or her discipline, and the specialists are obviously licensed, registered, or certified.

Home visiting models can have varying conceptual bases. Although they all take place in homes—in “natural environments”—they can differ considerably in their philosophical underpinnings and therefore their strategies. For heuristic purposes, the practices described here are those that place a heavy emphasis on supporting families, on functional programming, and on efficient service delivery. The starting place is the development of the intervention plan.

Intervention Planning

The decision to provide home-based services occurs during the development of the IFSP and IEP, theoretically. Once the outcomes or goals (the name depends on whether an IFSP or and IEP is being developed) have been selected, various service delivery options are considered. One of these is where the location of services. For children birth to 3, the team decision will often be the home. For older children it might be the home or it might be a classroom program. When children are already receiving services, changing locations might not be on the agenda, so the

intervention plan focuses more on what to work on and what services might be needed.

Home visitors should consider the use of a functional intervention plan, and one dimension of functionality with young children with disabilities is to focus on everyday routines. This can be done by gathering information about child and family functioning during routines, which is known as “routines-based assessment.” Another dimension of functionality in early childhood is the extent to which interventions match families’ priorities. The method of conducting a routines-based assessment, therefore, needs to give families a structure for identifying those priorities and needs to be done in a manner that supports them emotionally. The routines-based interview (RBI) does that. The goals of the RBI are to end up with a functional intervention plan and to establish or strengthen a good relationship with the family. The core elements of the RBI are described next

Routines-Based Interview

The three elements are preparation, the conversation about routines, and the process for selecting outcomes.

Preparation

In an initial IFSP or IEP, the family is asked if they agree to have a conversation with at least one person about home routines. The family is then asked to think about the different times of the day, in preparation for this conversation. They are asked to consider simply how each part of the day is working for them. In some programs, professionals give families a questionnaire about “your typical day.” On such questionnaires, the routines are often predetermined. To be sensitive to the different ways different families run their lives, it is better to let families define for themselves what routines they have. See the definition of “routines” in the consultation chapter.

If someone other than the primary caregivers cares for the child for more than about 20 hours a week, that person should

be involved in this process. This involvement can be done (a) by having the additional caregiver (e.g., a child care provider) present during the intervention planning meeting, (b) by gathering information before the meeting with the family, or (c) by reviewing the plan with the caregiver after the intervention planning meeting. Clearly, (c) is the least favorable option. The additional caregiver also considers how the different routines work for him or her and the child. Such routines in child care programs are often defined by the schedule, such as circle time, snack, small toys, playground, and so on.

The main feature of preparation is to prime the family and, if necessary, other caregivers to participate in the routines-based interview. But such preparation is not necessary. If the family does not think through routines before the meeting, the skilled interviewer can proceed anyway. In addition to the preparation for the conversation, logistics should be considered, such as where to have the meeting, who should be there, and what time it should take place.

Routines-Based Assessment

The first step in the RBI is the small talk that typically precedes any meeting with families. The interviewer then makes some preliminary remarks and begins asking questions:

1. What the purpose of the meeting is, along with a reassurance that, if more time is needed, such will be provided.
2. Who lives in the home (if this has not already been ascertained)?
3. Who is everyone around the table?
4. What are the family's main concerns?

The interviewer then moves into questions about the routines, starting with the beginning of the day for whoever is answering the questions (i.e., not the beginning of the child's day necessarily). A typical first question about routines is, "How does your day start?" To make transitions between routines, the interviewer asks, "Then what happens?"

Allowing the family to name the routines is better than moving through routines that an individual family might not have. During the discussion about each routine, the interviewer is trying to elicit information about the following:

1. What everyone in the family does at this time;
2. What this child does; and
3. How satisfied the family is with this routine?

When eliciting information about what the child does—Number 2 above—the interviewer asks questions about three areas of functioning: engagement (how the child participates in the routine), independence (how the child does things unassisted), and social relationships (how the child communicates with and gets along with others). The good interviewer gathers this information with the family mostly unaware of this structure. It should proceed like a conversation, so the affect, body language, and other nonverbal communication features are very important.

Outcome Selection

Having proceeded through the routines of the day and, if time, weekend and other routines, the interviewer then (a) reviews the areas of the family's concern expressed during the conversation, (b) asks the family what they would like to have on the plan, (c) asks the family if there are other things that did not come up during the RBI, and (d) asks the family to put that list into priority order. The review of concerns is designed purely as a reminder; it is not designed to lock the family into an outcome or goal. In fact, some concerns discussed volubly during the RBI do not get chosen to go on the list, and some new concerns end up on it. Families often choose 6-10 outcomes or goals, which might be more than is typical in early intervention programs. Surprisingly, a good RBI covers so much ground that families do not usually have other concerns to add. The only prediction that can be made about families' putting outcomes in priority order is that they will put those related to their

own needs as adults after the child's. Nevertheless, the process does elicit family-level outcomes.

Frequently Asked Questions

How much structure should be used in getting families to prepare for the interview? Although forms might be useful for some families (see McWilliam, 1992), it is not necessary to have a written record of families' perceptions of their routines. The routines-based assessment hinges on the interview itself. The main purpose of alerting parents to the content of the meeting is to give them an opportunity to go prepared.

What if there's more than one parent? The family should have the choice about who participates. If both parents are at the interview, the interviewer has to converse with both, diligently. They might give different answers, but most early interventionists know how to handle such situations.

What if the child spends his time with two separated parents? Whoever is participating in the RBI gets to dictate what routines are discussed. Families should be told that anyone with whom the child spends significant amount of time would be appropriate for involvement in this process (i.e., that person's routines are relevant).

What if there are constant interruptions? Interviews occurring in homes are often subject to interruptions. It is recommended that, because this meeting typically takes place only twice a year—owing to the federally mandated review and update schedule, families be asked to make interruptions as unlikely as possible. It is very important to understand that this is an exceptional situation, and families should not be pressed in this way for regular home visits.

What if it takes a long time? It often will take 1.5 to 2 hours. Families and professionals involved should know this ahead of time. In demonstrations for training, most family members have stated that the meeting took less time than it actually did. The time flies for participants.

Who should do the interview?

Different programs will adopt different criteria for the interviewer. In some programs, the discipline of certain staff members (e.g., social workers) has resulted in their being given this job. In others, the person most likely to be the service coordinator has take it. In yet others, certain staff members comfortable with interviewing have conducted RBIs, while others have not. Experience has shown that the most skilled interviewers are good listeners, informal, and ask relevant questions based on the child's disability, the child's age, and the family's background. Because of this last characteristic, it is important to know child development and family functioning.

Isn't this information confidential and private? Families are not forced to say anything they do not want to say, but most families are very happy to talk about life with their child. If the interviewer is interested, informal, and knowledgeable. The interviewer should reassure families about confidentiality. This question is actually somewhat of a nonissue, because families are either remarkably open or we would not necessarily know it. On numerous occasions, someone who knows the family has said that the parent being interviewed left out something important, embellished a truth, and so on. When asked whether the RBI resulted in a list of functional outcomes and established a positive relationship between the family and the professional, the answer has always been *yes*. This makes the point that the interview is of family perceptions—more specifically, what families choose to tell us. If the perceptions are entirely accurate or congruent with professionals' perceptions (and these two things are not synonymous), that is a bonus. It is not, however, a requirement. The process does not hinge on validity in the ordinary sense.

How do families react to the RBI?

The vast majority of families in many programs across the country have reported great satisfaction with the RBI. It is perceived to be (a) a good opportunity to

review the fit between the child and his or her routines, (b) an opportunity for rethinking interventions, and (c) a demonstration that the professionals care about the adult family members, especially the mother.

How is this different plan from traditional methods of determining outcomes or goals? Traditional methods often either are derived from tests or are the result of an ineffectual but well-meaning general question about what the parent wants for outcomes. The need for tests to establish eligibility is understood, but many programs simply skip this assessment of needs and desires. They assume that test-item passes and especially failures are relevant, which they often are not. The defining characteristics of the RBI, compared to traditional assessment, then are twofold:

1. The family has a very active role in both amassing information and making intervention decisions; and
2. The context of children's functioning is ever-present in the assessment, whereas in traditional testing the context is deliberately standardized to obviate the effects of different background environments as much as possible (see Dunst & McWilliam, 1988).

How many professionals are involved? Only one is necessary to conduct

the interview, but generally two professionals are involved. If this assessment is considered part of the multidisciplinary evaluation in Part C, at least two professionals from different disciplines must participate. Another practice consideration is that it is helpful to have one person concentrate on interviewing the family, while the other person takes notes, entertains the child, keeps the dog away, and so on.

The routines-based interview, therefore, is a formidable tool home visitors can use to develop a functional intervention plan and positive relationship with the family. The next step is actually to provide home visits.

Home Visits Themselves

For the purposes of this chapter, home visiting is defined as a professional's meeting the family at a place where the family would naturally be if the child were not receiving services, such as the home or a community setting. Many home visitors see children in child care settings, which is described in the consultation chapter. Traditional home visiting will be contrasted with a support-based model here, to explain how this form of service delivery can be driven by theory. Table 2 shows two approaches.

Table 2. Traditional versus alternative home visiting models.

Traditional home visiting	Another home visiting model
Before the visit, the visitor asks the parent to set up the environment.	The visitor ensures that the visit time is convenient for the family.
The visitor reduces distractions as much as possible.	The visitor asks how things have been going.
The visitor works with the child, using a number of materials she has brought on the visit.	The visitor asks about any significant family events or activities since the previous week.
The visitor asks the parent how interventions have been working since the previous time.	The visitor asks about routines the family has previously identified as those during which they were going to work on something.
The visitor gives the parent strategies for working on during the following week.	The visitor provides emotional support, deals with needs for material support, and provides informational support.
The visitor packs up her materials and leaves with them.	

The traditional approach (a) is similar to a clinic-based approach dumped on the living room floor, (b) is based on an assumption that the home visit is the time when the child is really learning, and (c) uses an expert model of consultation (see consultation chapter). In contrast, the other approach (a) is respectful and encouraging of families, (b) ensures that families' basic needs are attended to, and (c) deals with what to do with the child. These characteristics are not necessarily mutually exclusive. Practitioners of traditional home visits can, for example, encourage families. Similarly, practitioners of support-based home visits can "work with" the child, as will be described later. Nevertheless, the traditional approach (so called because it is old and popular) is professionally driven, therapeutically oriented, and paternalistic. The alternative model is family-driven, support oriented, and family-centered. The remainder of the chapter will discuss (a) the five types of home visits, (b) support-based home visits, and (c) home visiting concerns.

Five Types of Home visits?

PSP alone

In a transdisciplinary model, the PSP makes a visit by him- or herself, addressing multiple domains or areas of development. One quite-different variation on this has been visits by paraprofessionals or "lay visitors," which has led to some confusion about the purpose and effectiveness of home visiting. Many programs using lay visitors have resulted in poor efficacy data for this model of service delivery (e.g., Schuler, Nair, & Black, 2002). Most studies decrying the effectiveness of home visits were conducted with disadvantaged children, and the home visitors were lay people (e.g., Goodson et al., 2000), public health nurses (e.g., Zahr, 2000), or others who are different from today's early intervention home visitors.

Joint home visits

Joint home visits, in which two professionals go to the home together, are used with a transdisciplinary model but could also be used as supplements to the traditional model. In a transdisciplinary model, a specialist accompanies the PSP. The purpose of the joint home visit is the exchange of information among the family,

the PSP, and the specialist. The specialist is a consultant in the context.

Discipline-specific visits (without PSP)

Discipline-specific visits occur all the time in multidisciplinary models and might occur occasionally in other models. On these visits, one specialist visits the family on his or her own, and the topic is limited to the area of training, licensure, expertise, or comfort of the professional. Because of this restrictiveness, it is not unusual to find that families receive multiple visits like these per week.

Visit by classroom teacher

Another type of home visit is when the classroom teacher makes a home visit (e.g., Conduct Problems Prevention Research Group, 2000). These visits typically occur very few times a year, although in some combination placements, children might be served both in a classroom and at home. Ordinarily, though, the purpose of the visit is for the professional to get to know the family and to convey information to them.

Service coordination alone

Within Part C, the last type of home visit is that of the service coordinator's visiting, when the service coordinator is not also a PSP. These visits also typically occur very few times a year and are limited to decision making and sometimes to securing resources for the family.

Each type of home visit has its distinct purpose, so what happens during the visits differs by type. The most common home visits are those by one person. Home visits are described here in terms of a specific model consistent with current theory and research: support-based home visits.

Support-Based Home Visits

The theoretical framework for support-based home visits gives the reason for integrating specialized services and providing three types of support. Concerns with this model are described.

Theoretical Framework

The theoretical framework for support-based home visits hinges on understanding (a) how infants and toddlers learn, (b) how successful modeling for the family is, and (c) how often the family needs modeling. This shows the need for an alternative to traditional practices.

How do infants and preschoolers learn? Infants and toddlers learn through repeated interactions with their environment, dispersed over time. The younger the children, the more efficient it is to teach them on the run rather than in concentrated lessons. Children need multiple exemplars and multiple opportunities to practice a skill. When they are massed, as in a lesson or session, children (a) have no time to process each "trial," (b) do not learn the natural discriminative stimuli, and (c) do not experience natural contingencies. Learning opportunities spread through the day, introduced at naturally occurring moments, and consequated at least somewhat naturally are more likely to lead to children's learning. Those are the benefits to the child.

A benefit to the parent of a dispersed approach are that they do not have to restructure their day or their interactions to any great extent, thus ensuring more likely implementation of the techniques. Another benefit is that the intervention can help the routine or interaction by increasing the child's engagement, independence, or social relationships. This lesson, that young children learn through repeated interactions with the environment, dispersed through the day, is fundamental to the support-based model.

How successful is modeling for the parent? Once it is understood how young children learn, the home visitor might have to renegotiate existing schema about home visits. The traditional home visitor might have treated the "session" as a time to intervene intensely with the child, but, because of the way young children learn, such an approach might have been

misguided. Modeling requires the “learner” to be interested, watching, and, if possible, practicing with feedback. Simply going through activities with the child on a home visit does not necessarily constitute modeling. If the family is not paying attention, perhaps not even in the room, the modeling will be to no avail. Families who are interested in having the home visitor show them how to do something will pay attention. One element of a successful home visit, therefore, is the salience of the activities the home visitor proposes. Not only does the activity have to be interesting to the child—perhaps more importantly it has to be interesting to the adults who will carry out the interventions. Understanding how children learn leads to understanding the need to support families in their intervention roles.

How often does the family need modeling from a specialist? Because some specialists justify weekly home visits on the basis of the need to model, it begs the question, *how often does the family need modeling from a specialist?* If (a) the intervention is quite complex, (b) the specialist is still assessing the child, or (c) the interventionist is inexperienced or lacks knowledge, it is possible that frequent visits are necessary. If they are very frequent, it suggests that the PSP should be a specialist who is needed so often. It should be rare, however, for multiple professionals to need to model interventions week in and week out.

The need for an alternative. Because of the way children learn and the reality of modeling, an alternative to dumping a clinic-based model on the living room floor is needed. An alternative to the agenda based on the toy bag is needed, so home visitors can put the principles into practice. The new agenda should be the complex, interrelated needs of developing children and their families. As will be discussed, support-based home visits provide this direction.

Reasons integrated (transdisciplinary) services are appropriate.

The PSP model is appropriate, then, for five reasons.

1. The child-level intervention occurs *between* visits (i.e., the purpose of sessions is to provide informational support to regular caregivers).
2. There's more than one way to skin a cat (i.e., no specific intervention is so necessary that a normalized alternative can't be found).
3. Therapy and instruction are not tennis lessons (i.e., children cannot transfer therapy-time skills to nontherapy times).
4. Not every need requires a service.
5. More is not necessarily better.

Implementing Integrated Specialized Services

Once the outcomes or goals have been identified, services and resources need to be decided upon. (Note that often services are erroneously identified on the basis of diagnosis—what a child is eligible for—not on the basis of need.) Most practitioners are familiar with the idea of making these decisions on the basis of child characteristics—such as diagnosis and severity of the child's disability, but few are familiar with the making decisions on the basis of the needs of the caregiver and the PSP. If the caregiver (i.e., parents or child care providers) is confident and understands what to do with the child, specialists do not have to keep visiting week after week. If, on the other hand, the PSP is having difficulty helping the family, specialists might be needed to develop alternative programs. Perhaps the most critical issue for deciding on intensity is the confidence and competence of the PSP. Weekly home visitors who are experienced and knowledgeable will be able to understand the specialists' programs and help the family carry them out. Home visitors with little experience in this type of work, with a particular disability, or with a particular type of intervention might need more frequent visits than would the experienced PSPs. It is rare for IFSP or IEP teams to consider the home visitor's skills,

but this should occur. In fact, teams usually avoid the question by simply having multiple specialists visit every week.

Implementation therefore can involve both the adoption of the PSP model and then decisions based on that person's competence and confidence. Once the PSP has been identified, most specialist visits occur jointly with the PSP. The dangers of separate visits by individual specialists are (a) they tend to escalate (more and more reasons for such visits become manufactured), (b) they undermine the PSP, (c) they reinforce the notion that the visit itself is more important than what happens between visits, and (d) they underline the notion that different problems require different services (when, in fact, some do and some don't). The decisions about intensity and the policies for how the team will provide services should, therefore, be made early in the process.

The Three Types of Support

Why is the model called a "support-based" model? It is based on the following premises: (a) that support to families is a fundamental purpose of early intervention (see Bailey, 2001; Cohen & Wills, 1985; Dunst, Jenkins, & Trivette, 1984), (b) that support to the family is the most effective way of ensuring that children receiving home-based services receive *intervention* (Dunst, Trivette, & Deal, 1994; McWilliam & Scott, 2001), and (c) that all early intervention activities can fall into the umbrella term *support*. Using this term helps reinforce the support concept and weaken the concept that home visits should be concentrated on direct, hands-on intervention by a weekly visitor. The three types of support that appear to be basic to early intervention are emotional, material, and informational support. As each is described below, it will become clear that they happen together, that different types of support (and even different components within them) are more appropriate for certain families at certain times than are others, and that attention to both children and families is involved.

Emotional support. Emotional support described the way home visitors treat families, but it also involves what they talk about on home visits. In a study of family-friendly service providers, five themes were discovered. First, they were *positive* about both children and adults in the family. Not only did they make upbeat comments about the child but they complimented the adults. Second, they were *responsive* to families, not simply listening but actually taking action when that was appropriate. They also sought to fix problems with service delivery—sometimes problems about their own practices. It was notable that they were never defensive. Third, they were *oriented to the whole family*, not just the "client" child. For example, they showed an interest in siblings and extended family but, most important of all, they were extremely oriented to the well-being of the primary caregivers (e.g., mothers). Fourth, they were *friendly* in a manner that went beyond "rapport," which tends to be the behavior of professionals reaching out—perhaps down?—to clients. They treated families as they would neighbors. Fifth, they were *sensitive*, as though they could walk in the family's shoes. In home visiting, this was particularly evident in matching the amount and difficulty of suggestions to what they parents indicated they wanted to handle.

Two other characteristics also were apparent. They were knowledgeable about the community and about children. They were able to direct families to community resources ranging from formal supports such as dentists to merchants who could give them a good deal. Their knowledge of children was not only valuable to families; families actually reported that it was an absolute necessity. These family-centered service providers had to be able to ask relevant questions, give practical suggestions, and have access to expert knowledge about raising children.

These characteristics are not all those involved in providing emotional support. Home visitors need to be able to

listen well, to “empower” families with decision making, and to encourage families. But the five characteristics (plus knowledge about communities and children) provide a helpful outline to guide home visitors in how to provide emotional support.

Material support. Material support involves ensuring that families have the resources to conduct their lives. In early intervention, it can involve specialized equipment that might be helpful for the child’s or family’s functioning. It should always involve ensuring that families have basic needs, such as shelter, food, clothing, diapers, formula, and so on. Apart from this being humane, it has psychological benefit, as Maslow (1943) described long ago. Early interventionists’ responsibilities are often to provide families with the information about material resources, including such financial resources as Temporary Aid to Needy Families; Women, Infants and Children nutrition vouchers; and Social Security Income. Incorporating service coordination into IDEA Part C has helped families receive this type of support.

Informational support. Informational support is simply providing information to families. Research has shown that families consistently want information, even when they are pleased with services. There are four types of information families often want. First, they want to know about child development, sometimes to know what children their child’s age should be doing and sometimes to know what normally comes next. Second, they want to know about the child’s condition or diagnosis. Many disabilities and medical conditions are either unknown to families, or families have misconceptions about them. Third, they want to know about resources, such as services and support groups. This becomes particularly acute when they face a transition, such as the transition that typically occurs when the child moves from Part C to Part B. Fourth, they want to know what to do with their child, which arguably has constituted four fifths of home visitors’ activities. Because intervention for children

really occurs *between* home visits, the role of home visitors is to provide families with the information they need to carry out those interventions. This information about intervention can involve the home visitor’s watching the child, playing with the child, talking to the family, and showing the family. It therefore very much involves the child, but it is important to understand that activities with the child are for the purpose of informing the family. The activities with the child have limited if any direct intervention effect, for the developmental and learning-theory reasons given earlier.

Emotional support, therefore, involves both how families are treated on home visits as well as what topics are addressed. Material and informational support involve what topics are addressed. The three types of support cover almost everything that occurs during a home visit.

Addressing Concerns

The support-based home visit challenges some home visitors who are used to a more didactic, hands-on philosophy. Five concerns are addressed here: the irrelevance of the toy bag; the apparent diminishment of child-level intervention; problems with modeling; home environments; and different adult family members.

How to ditch the toy bag. What’s wrong with the toy bag?

- It gives the impression that the home visitor thinks the existing toys and other materials are inadequate;
- It reflects an assumption that the home visit is when learning occurs, instead of between home visits; and
- It involves assumed intervention with objects the child does not have.

Because home visitors should be affirming families, including what the child has to play with, they should use existing toys and materials. In any case, the child needs to learn to play with what is in the environment, not what is brought in from an early intervention program. If the family and interventionist decide that a child could benefit from something the child

does not have, and if such a discussion would not undermine a family's confidence, the interventionist could bring a toy for the child to try out or even keep.

Traditionally, toy bags have often constituted the home visit agenda. The home visitor goes through the different activities with the child. Adult family members have either watched or participated. Another option some families have chosen is to attend to other things while the home visitor is "working with the child." Ironically, those home visitors are likely to say that such parents are not "involved." In the support based model, (a) the home visitor is visiting the adult family members, (b) talks through interventions with the family, and (c) demonstrates interventions with the child. Consequently, such families do not wander off or stop paying attention.

A conversation about routines and other matters replaces the toy bag as the agenda for home visits. The following kinds of questions are appropriate:

- How have things been going?
- What about breakfast, getting people out of the house, the hours from Hell, etc.?
- What did you do last weekend?
- Did you have any appointments? Any coming up?
- Is there a time of day that's not going well for you?
- In the past week, what time of day has been going well (with or without the child!)
- Do you have enough to do with your child? Too much?

This kind of conversation might seem too simple, but the skilled home visitor asks appropriate follow-up questions and the answers lead to all kinds of activities. They lead to the home visitor's talking, showing, and reviewing.

What about child-level intervention? Professionals who are used to "teaching" or "providing therapy" on home visits might be concerned about the role of

child-level intervention. Actually, the most effective child-level intervention on home visits is carried out through and by the adult family members. The difference between the old and new models is that in the new model the home visitor is not responsible for the actual implementation of the interventions, just helping to design them with the family.

Frequently, the home visitor ends up demonstrating for the family, but demonstration should be used judiciously. When it becomes apparent that a child isn't doing something as desired, and the parent wants help, the home visitor makes suggestions. If the parent wants to be shown what to do, or the home visitor can't clearly describe what to do, the home visitor can model.

What are the three reasons for putting your hands on a child? Modeling for the family is one of three reasons for handling children on home visits. The other two are to assess the child and to be affectionate with the child. Assessing the child while physically interacting with him or her would be as part of functional or dynamic assessment rather than as part of formal, standardized testing. Showing affection is important when working with small children and when establishing positive relationships with families.

When do you need a specialist to consult with a family about a problem? Child-level interventions are happening all the time, whether we like it or not, because families are interacting with their children. The children are learning from those interactions. The regular home visitor (e.g., the PSP) should have enough expertise to guide families about interactions and interventions that cut across diagnostic types, across ages, and across families. They should know about normal development, about analyzing behavior, and about the basics of most disabilities. When a question outside these parameters arises, home visitors should obtain consultation from specialists. If specialists on the team are concerned that the home visitor might not know when to call them for consultation,

they should advocate for periodic check-ins with the family through joint home visits with the PSP. In general, therefore, child-level intervention is still a central part of home visits. It is simply that a professional's direct intervention with the child is not as important as the professional's intervention with the caregivers who spend enough time with the child to make a difference.

The eight steps of modeling: avoiding the model-&-pray approach. Consultation with families on home visits often involves modeling, but how effective those models are is questionable. Home visitors often sense that the models they have provided the week before have not been imitated. Many home visitors have used the model-and-pray approach, where they "modeled" and prayed that the family would spontaneously imitate the modeled intervention. A more effective approach would be to use modeling methodically. Table 3 shows eight simple steps that should be followed in a naturalistic and easy way.

Table 3. The eight steps of modeling

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

These eight steps (a) ensure that the family is rally interested in the intervention; (b) give the family two input modes, visual and auditory; and (c) give the family the opportunity to practice.

The inherent challenges of home visits. Home visits come with challenges. Some homes are very chaotic and some are very dirty. Sometimes, people the home visitor does not know are present. Sometimes, despite the home visitor's best practices, the parent will be distracted. And sometimes, pets, other children, and other adults will become involved.

Families themselves. Any time professionals are working with families, they need to be prepared for all sorts of situations. Because early intervention occurs at a time in a family's development that is intense and unfamiliar, home visitors encounter many reactions to them and to home visits. Families can be happy, distrustful, upset (sad, worried), angry, intense, and uninterested. By and large, however, families enjoy their home visits and love their home visitors. Home visitors, therefore, have a considerable responsibility to return that trust and affection.

Home visits can thus be centered around the provision of emotional, material, and informational support. This can be done by integrating specialized services in the PSP model, which is based on the recognition that intervention is what the child receives from the people who spend significant amounts of time with him or her. With the realization that this is the most common form of service delivery for infants and toddlers with disabilities and their families, it is important to carry it out with competence, knowledge of child development and family functioning, and common sense.

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