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Principles of the Routines-Based Model

Early intervention is a complicated and multifaceted enterprise, to the extent that we might lose sight of the major components of what we need to do, to support young children with disabilities and their families. Here, I offer the key three components that we should (a) remember in our work, (b) train students and learners in our pre- and in-service training, and (c) use to evaluate our results.

All the Intervention Occurs Between Visits

Children learn from their parents, whether we want them to or not. They also learn from other adults who spend much time with them, such as babysitters, other family members, child care providers, and preschool teachers. A visit to or by an early intervention professional might be for one hour a week. In multidisciplinary service delivery, this might be multiplied by the number of services the "child" receives per week. For example, a child might receive one session with a psychologist (in Europe, probably not the U.S.), one session with a speech-language therapist, and one hour with a physiotherapist. In fact, in some countries, that's pretty much the service line-up for every child. Each professional, in this scenario, provides direct, hands-on intervention to the child, in the hope that this miniscule moment in the child's week has a dramatic impact on the child's functioning. Sometimes, the therapist shows or explains to the parent what the strategy is, in the hopes that the parent will carry it out at home. Various problems exist with this method of working with parents.

First, the solution to the problem the therapist might have found might not be the best one for that child and family. Later, I will talk about using adult-learning theory, when I talk about working with families. Second, the demonstration is only as good as the interest of the family in the demonstration. We know from andragogy (Knowles, 1978) that families are likely to pay attention only as much as they are interested. Third, children don't learn in single sessions. Even if the visit is one hour long, any one skills is worked on for only perhaps 10-30 minutes, because of the child's attention span. Fourth, children under age 6 don't generalize well, without an adult's providing the generalized stimulus. Just because an early interventionist can get a child to do something during a hands-on session doesn't mean that child will perform similarly with other people in other situations. No: Children learn throughout the day from the people they live with—parents and other caregivers.

Therefore, our "sessions" need to be for the benefit of caregivers. Some people have referred to this as "building the capacity of caregivers" (Dunst, Bruder, & Espe-Sherwindt, 2014; Woods & Brown, 2011). I'm not sure this is the right term, because "capacity" sounds like the *amount* they can do. I'm not sure it's about increasing amount, which implies they might be deficient in what they can do. Instead, perhaps we should stick to sessions being to "support" families. I have talked before (McWilliam & Scott, 2001) about three kinds of support we should ensure families have: emotional, material, and informational. It's not about us providing it as much as helping families have these three types of support, about which I talk next.

Support to Natural Caregivers

If all the intervention occurs between visits, this has implications for what happens during the visit. If we define "intervention" as what the child receives, then the session with a professional is the service—that's what the family receives. Or what the child's regular-education teacher receives, if the child is in an inclusive classroom program.[1] In weekly service sessions, the visit should be prepared to provide the three types of support.

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[1] In a self-contained classroom, the special education teacher in charge of the classroom is providing both intervention and caregiving, but the therapists who visit the classroom are providing a service only.

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Emotional support means attending to the family's feeling of well-being, confidence, and competence. In a qualitative study with 72 families, we uncovered five characteristics of family supportiveness:

1) Positiveness. When professionals made affirming statements about both the child (the easy part) and the adult (the harder part), they were considered family centered and emotionally supportive. For example, when the professional told the mother she was a good mother, setting aside the old stricture against supposedly judging parents when using that kind of language. A mother likes nothing more than to be told what a good one she is.

2) Responsiveness. Alarmingly, Spanish has no good translation for this word or for a number of other words related to emotions. Responsiveness meant that professionals read between the lines, as families spoke. One has to be careful, however, not to jump to assumptions or to psychopathologize families. If you think they are trying to say something indirectly, it's best to ask. If they realize you caught their drift, they will be grateful. The other aspect of responsiveness was following through. For example, if a family said they wanted information about something, the emotionally supportive professional would e-mail the family as soon as he or she had it or would ensure he or she had it at the next visit. Families could count on their early interventionist.

3) Orientation to the whole family. Family-centered professionals referred to members of the family other than the child and the parent present, showing the family they understood the child and parents lived in a context of other people. The most important person other than the child is the primary caregiver, whose well-being is tied to the child's. For example, emotionally supportive professionals asked about the health of an ailing grandmother or remembered a sibling's birthday. More important, they frequently checked on how the mother (or father) was doing.

4) Friendliness. Emotionally supportive professionals treated families with respectful informality, as friends might. They did not insist on professional formality. Examples tend to trivialize this characteristic, as it's one of attitude as well as behavior; it's about being authentic and positive (see above).

5) Sensitivity. This characteristic of family-centered professionals is somewhat similar to responsiveness, but it's about being able to walk in the family's shoes—to understand what their life must really be like, even if quite different from your own. These professionals would, for example, understand that the mother did not want to teach her child independent play during dinner preparation time: She wanted the child to be able to play *without* her help. (Yes, there are solutions to this that don't require direct teaching by the mother.)

The second type of support we should ensure families have is **material support**—that they have the things families need to function as individuals and a unit. The first things are basic needs, such as food, clothing, and shelter. If we know a family needs these, we should spend our time ensuring they have access to resources who can help with these. In this model, we develop ecomaps with families, and, in a situation like this, we would look at the ecomap with the family, to see if anyone in the family's informal support network can help. If no one there, then we would look at the formal supports. If no one there, then we would look for additional resources.

The other aspect of material support is ensuring the family has the adaptive equipment or technology the child might need to function effectively in daily routines. You need to be careful, however, not to abnormalize a family unnecessarily by providing adaptive equipment that could have been handled by everyday objects. For example, if a child could benefit from games over a bolster, why not use the adult's thigh?

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You should pay particular attention to communication. You shouldn't wait until a child is much older than 2 years of age to decide on a communication mode, such as oral, manual (i.e., signs), or pictorial. Children should have a communication method by age 2.

The third type of support is i**nformational support**. Families almost always want information, usually about four topics:

1. The child's disability, condition, or diagnosis;

2. Child development, as in what this child should be able to do next or what other children of this age typically do;

3. Resources, including services, especially at transition to preschool services or transition to kindergarten; and

4. What to do with the child, which is to say interventions.

When we think of the fourth topic, interventions, it makes us realize that early intervention services, whether provided by educators, occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), or people from other disciplines, are about the provision of informational support. In other words, for example, OT = providing informational support. This notion is horrifying for professionals who believe strongly in their hands-on work with children, but the point of this section is that hands-on, direct service delivery is not the most effective method in early intervention birth-5. I am not saying the expertise of professionals isn't needed: To the contrary—specialists need to have two levels of expertise. First, they have to know early childhood and normal and abnormal functioning in their area. Second, they also have to know how to consult with adults in the child's life to help with the child's development.

Therefore, working on emotional, material, and informational support is a key feature of supporting families when we understand that all the intervention occurs between visits. For classroom teachers, the support we provide is collaborative consultation, described later.

Functional Skills
The Routines-Based Model is concerned with children's functional skills, meaning the skills the child uses to participate meaningfully in his or her home, school, and community routines. Routines are defined primarily as times of day, such as waking up time, breakfast time, and playtime. They are not behaviors, such as eating, toileting, or talking. I have little time for so-called prerequisite skills because (a) often they are not truly required before a child can acquire the next most successful skill and (b) caregiver motivation to work on a strategy that has no immediate payoff is low.

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In engagement theory, the three foundations of learning are engagement, independence, and social
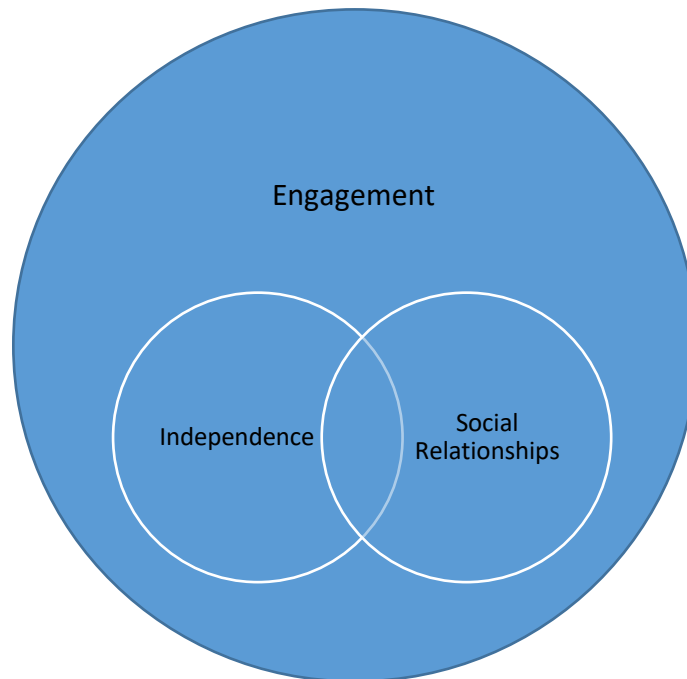
Figure 1. Three foundations of learning

relationships. In fact, independence and social relationships are subsets of engagement, so they can be shown as in Figure 1.

When you consider a child's participation in a given routine, you can gather information about his or her engagement, independence, and social relationships (EISR). In this model, two methods are used to collect such information: the Routines-Based Interview, for helping families determine the goals of intervention; and the Measure of Engagement, Independence, and Social Relationships (MEISR) (McWilliam & Younggren, in press), to monitor child progress. Those who know authentic child functioning are those with many hours (e.g., > 15) with the child during the week. Therefore, they are the informants in the RBI and the MEISR. The following kinds of questions tap into the construct of **engagement**:

- How does the child participate in this time of day?
- How does the child spend most of his or her time during this routine?
- How sophisticated is the child's behavior at this time of day?
    - Nonengaged (not participating)?
    - Passive attention?
    - Repetitive behavior?
    - Differentiated behavior?
    - Solving problems?
- Following the rules of the routine?

Why is engagement so important? First, the amount of time a child spends in a kind of interaction with a person or an object is related to mastery of the skill, and engagement is measured by amount of time. It is also measured in

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terms of sophistication. Just like in typical development, where infants primarily pay attention to their surroundings, then use repetitive behavior, later differentiated behavior, and then sophisticated behavior, so our interventions follow this increase in the sophistication of engagement. We work with caregivers to teach children to be more complex in their interactions with their environment in different routines.

The RBM, described in https://naturalenvironments.blogspot.com/, has these three principles: an understanding that the intervention occurs between visits, that we must therefore support natural caregivers, and that children's functioning (engagement and meaningful participation) is our goal.

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