CHAPTER 9

ASSESSING THE RESOURCE NEEDS OF FAMILIES IN THE CONTEXT OF EARLY INTERVENTION

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Henry Miller wrote, "Life is constantly providing us with new funds, new resources, even when we are reduced to immobility. In life's ledger there is no such thing as frozen assets" (1956, p. 33). As soon as families are enrolled in early intervention, someone needs to figure out what resources families need in order to accomplish their priorities. This chapter discusses families' resource needs and provides a specific method for determining the needs.

Guralnick (1997, 1998) has proposed a model of factors influencing children's developmental outcomes and applied that model to the design on early intervention systems (the Developmental Systems Model; Guralnick, 2001). These outcomes are most proximally affected by family patterns, which in turn are affected by family characteristics and potential stressors to these family patterns created by the child's disability or biological risk. Those stressors are information needs, interpersonal and family distress, resource needs, and confidence threats. Although these stressors to family patterns of interaction cannot easily be separated, this chapter focuses on resource needs.

RESOURCE NEEDS

Resources covers much territory and has been used in early intervention to include the assets families have (Dunst, 2001; Part C of the Individuals with Disabilities Education Act [IDEA] Amendments of 1997 [PL 105-17]); material support, such as financial assistance and equipment (McWilliam & Scott, 2001); and potential places, activities, and settings in which intervention can occur (Trivette, Dunst, & Deal, 1997). The importance of the definition of resources is revealed by the widespread description of early

intervention as a set of *services,* which is too narrow. A *resource*-based approach is preferred (Trivette et al., 1997) because it can encompass but go beyond services, especially to include community activities, places, and events (Schwartz & Rodriguez, 2001). Outside of the United States, this approach has been tried at the community level: One Portuguese city explicitly designed community-based early intervention to use existing community resources, along with health care, education, and social services (Boavida, Espe-Sherwindt, & Borges, 2000). Approaching early intervention with a focus on resources entails a comprehensive set of professional activities.

Professionals' and families' focusing on resource assessment and intervention has had direct and indirect consequences for families. For example, one of the rationales for this approach in social work is that obtaining resources might be a vehicle for establishing a positive relationship with the family (Atkins-Burnett & Allen-Meares, 2000). Therefore, resources are both an end and a means.

Resources discussed here are heavily concentrated on *external* resources compared with intra-individual characteristics that would be considered *internal* resources. Internal resources are, however, important, as seen in research on out-of-home placement in which the extent of external resource use was found to be related to plans to maintain the child at home until age 21, over and above child-related stressors and family resources (Cole & Meyer, 1989). Yet families with high levels of internal resources were more apt to report plans for keeping the child at home indefinitely. Another internal resource is parents' locus of control. In a study of family-centered early intervention programs, families' indications that they had control over services, resources, and supports were considered a positive outcome (Trivette, Dunst, & Hamby, 1996). Judge (1997) found that professionals' appropriate help-giving practices were associated with families feeling in control; therefore, assessing resource needs appropriately requires a process that addresses both external and internal resource needs.

FAMILY NEEDS

Families need emotional support, material support, and informational support. *Emotional support* from early intervention providers consists of behaviors and attitudes such as being positive with and about children and parents, being responsive, showing interest in the whole family, being friendly, and being sensitive (McWilliam, Tocci, & Harbin, 1998). In a study of multicultural infants and toddlers who were deaf and hard of

hearing, one of the most helpful resources for the families was "service with heart" (Wu, 2002, p. 42).

Material support consists of access to financial resources, equipment, and other objects that help families achieve their tasks (McWilliam & Scott, 2001). One potential material support need of families is related to employment. In a British study of parenting and employment decisions of parents with a preschool child with a disability, a disproportionate number of mothers were employed only part time, compared with mothers of children with typically developing children (Cuskelly, Pulman, & Hayes, 1998). The mothers of children with disabilities reported that the medical needs of the child were the reason for their employment situation. If a family needs material support, then it is significant because it is likely to have an impact on their ability to carry out interventions (Maslow, 1943).

Informational support is the third type of support or resource that families are likely to need. They often need information about their child's disability, resources about services, typical child development, and what to do with the child (McWilliam & Scott, 2001). Informational support is the crux of early intervention and is what home-based therapy and special instruction should consist of (McWilliam, in press). Early intervention programs have been found to provide higher levels of family services related to informational support (i.e., child information, family instructional activities, systems engagement) compared with material support (i.e., personal and resource assistance; Mahoney & Filer, 1996).

When considering families' needs, it might be worth exploring fathers' needs individually. In a British survey of 189 fathers of children with developmental disabilities, the fathers' top priorities were informational support, specifically information about their child, and materials support, specifically available resources (Hadadian & Merbler, 1995). American fathers have reported, however, that they prefer activities that are not separate from the rest of the family (Turbiville & Marquis, 2001). Therefore, families tend to need various types of support—emotional, material, and informational. The last two are commonly considered "resources."

ROUTINES-BASED ASSESSMENT

A practical approach to assessing families' resource needs is a routines-based assessment, which is an exploration into the daily functioning needs of families and children, organized by times of the day and frequently occurring events. This section defines *routines* and presents the conceptual framework for this kind of assessment. The central feature of the assessment is explained, and implications for intervention planning and service delivery are discussed.

Definition of Routines

Routines are defined as the events and activities of family life that occur with some regularity. They are not established times of the day, although, within one family, they often happen in a predictable order (e.g., waking up is followed by a diaper change, which is followed by breakfast). Some routines are daily and others less frequent. For example, going to preschool 3 days per week, going to church weekly, going to a doctor monthly, and so forth all can be considered routines. Sometimes families discuss family interactions that have become rituals (see Schuck & Bucy, 1997), so they would be included. Typically, however, routines are commonplace activities or events.

Conceptual Framework

Four traditions in early intervention come together to form the conceptual framework for this method of assessing needs. First, the use of routines or niches as an organizing framework for child and family functioning has been useful for assessment and intervention (Bernheimer & Keogh, 1995; Weisner, Bausano, & Kornfein, 1983). Second, a support paradigm has been used to explain variation in early intervention outcomes (Bronfenbrenner, 1979; Cohen & Wills, 1985; Dunst, 1985) and to systematize home visiting practices (McBride & Peterson, 1994). Third, a functional concept of child behavior, rather than a test-domain concept, has been articulated in a routines-based approach to intervention planning (McWilliam, 1992). The functional categories of behavior are engagement, independence, and social relationships. Fourth, quality of life has been identified as a worthy family and child goal of early intervention (Mitchell, 1993). This is indicated, in this framework, as satisfaction with routines.

Within the context of routines, support enhances child functioning in that 1) emotional support provides encouragement; 2) material support provides the necessary resources both for children to be able to do things independently (e.g., equipment) and for families to be able to meet basic needs (e.g., financial resources); and 3) informational support leads to intervention. In turn, if the child is functioning through engagement, independence, and social relationships, then the family's quality of life is likely to be enhanced. Children will participate, do things on their own, get along well with others, and be able to communicate. Family satisfaction with routines is proposed as an indicator of the family's quality of life. Not only does support have an impact on quality of life when mediated by child functioning but also it is theorized to have a direct effect. Thus, the extent to which families receive emotional, material, and informational support is considered to have an impact on families' satisfaction with routines. Eventually, these direct and mediating effects need to be tested empirically. Theoretically, however, this is the conceptual framework for the routines-based approach to assessment of resources.

Routines-Based Interview

One proven way to determine families' past and current resources is to interview them (Winton & Bailey, 1988; Wu, 2002). The routines-based interview (RBI; see Figure 9.1) process described here was published previously in a book on family-centered intervention planning (McWilliam, 1992). Since then, hundreds of practitioners have been trained, and the RBI has been institutionalized in a number of states (e.g., Colorado, Nevada, and New Mexico have incorporated it into their Part C system). The RBI requires preparation, which includes making decisions about settings and people. The interview itself concludes with the family's making decisions about intervention.

Preparation

Giving families an opportunity to prepare is respectful. For the initial development of an intervention plan (i.e., individualized family service plan [IFSP] or individualized education program [IEP]), the interviewer typically will have basic demographic information, assessment results, and the family's main concerns, which are usually discussed during the intake process. If a plan is being developed for a child already in an intervention program, then the interviewer might have had contact with the child and family if he or she is a member of the child's intervention team.

The family is asked to consider what goes on during different routines, how the child manages, and whether the family would like to change anything about the routines. The interviewer can devise a simple form for families to write out their routines and any changes they would like to make (see McWilliam, 1992; only available through http://www.VanderbiltChildDevelopment.us).

Options for Settings and People

The interview can take place anywhere. For children in birth to 3 programs, it often will be appropriate for the interview to occur in the home; for older children, it might take place where other administrative and assessment activities take place, such as in an office, conference room, or empty classroom.

Who should be present at the interview? Inform the family about how the RBI will be conducted so that they can decide whom they would like to participate. Minimally, one parent (the primary caregiver) needs to

Routines-Based Interview (RBI) Report Form

Directions:

This form is designed to be used to report the findings from the McWilliam model of conducting a routines-based interview. A second person (e.g., someone assisting the lead interviewer) can use the form to summarize the discussion during the interview, or it can be filled out at the end of the interview.

1. Complete the information below.
2. For each routine, write a short phrase defining the routine (e.g., waking up, breakfast, hanging out, circle, snack, centers).
3. Write brief descriptions about the child's engagement in the Engagement box (e.g., participates with breakfast routine, bangs spoon on the high chair, pays attention to the teacher, names songs when asked, often leaves circle before it has ended).
4. If the interview revealed no information about one of the three domains, circle No information in that domain for that routine.
5. Write brief descriptions about the child's independence in the Independence box (e.g., feeds herself with a spoon, drinks from a cup but spills a lot, sings all of the songs with the group but needs prompting to speak loudly enough).
6. Write brief descriptions about the child's communication and social competence in the Social Relationships box (e.g., looks parent in the eye when pointing to things in the kitchen, pays attention to the teacher at circle but can't stand touching other children).

Child's Name	
Date of birth	
Who is being interviewed	
Interviewer	
Date of interview	

Routine	No information
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (circle one) 1. Not at all satisfied 2. 3. Satisfied 4. 5. Very satisfied	*Classroom:* Fit of routine and child (circle one) 1. Poor goodness of fit 2. 3. Average goodness of fit 4. 5. Excellent goodness of fit

Domains addressed (circle all that apply):
Physical Cognitive Communication Social or emotional Adaptive

Routine	No information
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (circle one) 6. Not at all satisfied 7. 8. Satisfied 9. 10. Very satisfied	*Classroom:* Fit of routine and child (circle one) 6. Poor goodness of fit 7. 8. Average goodness of fit 9. 10. Excellent goodness of fit

Domains addressed (circle all that apply):
Physical Cognitive Communication Social or emotional Adaptive

Figure 9.1 Routines-Based Interview (RBI) Report Form. (McWilliam, R.A. [1992]. *Family-centered intervention planning: A routines-based approach.* Tucson, AZ: Communication Skill Builders. Reprinted by permission.)

be present; the family itself can decide how many other family members should participate. Families also should have the choice of anyone else they would like. They should know, however, that the discussion would be centered around everyday routines, so that might have some bearing on whom they would like to participate.

When Does the Routines-Based Interview Take Place?

The RBI typically occurs just before the completion of the IFSP or IEP. The following process is what typically occurs in infant-toddler services. It begins with a referral and an intake contact. At the intake contact, among other activities, the professionals ask the family about their major concerns and seek permission to evaluate the child. The person doing the intake will find out whether the child is referred because he or she has an established condition or is suspected of having a delay. The RBI plays a slightly different role with each of these methods of entry to the system. When the child has an established condition, a multidisciplinary evaluation is required but *testing* is not. In fact, many states and local programs still test children as their method of conducting a multidisciplinary evaluation. In many states, the RBI can be used as the method of assessment because, if conducted right, it produces descriptive information about all five domains required in IDEA '97: cognitive development, physical development, communication development, social or emotional development, and adaptive development. If two or more professionals were involved in the RBI, then it can be considered a multidisciplinary evaluation. The term *multidisciplinary* should not be confused with a philosophy and method of service delivery (e.g., interdisciplinary, transdisciplinary). It simply refers to the number of professionals. Technically, a multidisciplinary evaluation, as defined in the law, could be conducted in a transdisciplinary fashion (see Linder, 1990).

When the child is suspected of having a delay, testing is necessary in most states. Professionals conduct a norm- or criterion-referenced test to determine whether the child's scores meet eligibility criteria. Results of the testing determine whether the child can proceed in receiving services. The RBI can still be used to gather a description of the child's functioning because completing test items clearly does not indicate functional needs for intervention. There is still a need for a process to identify meaningful outcomes for children who are eligible for services based on their tested delay.

The RBI can be the single point at which functional needs are assessed and families make their outcome choices. With eligibility no longer in question, it is worth the investment of professional time to conduct a lengthy interview to obtain a description of the child's current level of

functioning; determine the family's choice of outcomes; and determine their concerns, priorities, and resources (described later in the chapter).

Family Preparation Form

The Family Preparation Form (McWilliam, 1992) was designed to help parents sort through relevant information before the RBI. The rationale was that professionals, who know how the process works, go to IFSP or IEP meetings with the confidence that they have enough information (e.g., assessment reports, an intake report, medical records) to participate meaningfully. Families, however, might not know how to prepare to participate meaningfully, especially if it is their first planning meeting. The Family Preparation Form provides them with an opportunity to list their major concerns and identify their routines. For each routine, the family is asked to consider what everyone in the family does at that time, what the child does, and whether they are satisfied with the routine.

Who Should Conduct the Interview?

Conducting an RBI is ostensibly simple but operationally complex. The skillful interviewer keeps the tone conversational, is positive and affirming, asks relevant questions, and above all is friendly and informal. The structure will be described in the next section, but the appropriate people for interviewing the family need to be considered early on. Programs can consider the following options: 1) everyone who works with families; 2) professionals who have an affinity for this type of clinical activity; 3) members of an evaluation team; 4) dedicated service coordinators; 5) members of a certain profession, such as social workers or psychologists; 6) those who are most likely to be providing ongoing services to the family; 7) those who have something in common with the family, such as neighbors or those who speak the same language; and 8) those who have expertise in the disability of the child.

In 20 years experience with the RBI, none of the options has proven to be the sole answer, and many programs have chosen various combinations of the options. The three characteristics most important for successful use of the RBI are 1) conveying acceptance with no implication of passing judgment; 2) being informal and friendly; and 3) knowing child development, family functioning, and disabilities. It is unfair to lump three large bodies of knowledge into one characteristic (Item 3), but this is information that professionals can learn.

How Many People Are Involved?

Often, two people are involved in the RBI. If it is used for the multidisciplinary evaluation, then representatives of two disciplines or professions must

be involved. When professionals are first using the RBI, it often is helpful to have a second person to ask additional questions, take notes, or handle interruptions. Ultimately, programs need to make a decision based on how many people are legally required and what is expedient for the program.

The Interview

The interview has two distinct stages. First, the interviewer explains why he or she will be asking about child and family functioning during everyday routines: to get relevant information to be able to make wise recommendations and to provide a framework for the family to decide what they want to work on. Second, the interviewer begins with the beginning of the respondent's day and asks five questions for each routine: 1) What does everyone do at this time? 2) How does the child participate (engagement)? 3) What is the child's independence like? 4) What are the child's social relationships like? 5) How satisfied is the parent with this routine? This is the bulk of the interview and can last more than an hour.

The RBI form (available from http://www.IndividualizingInclusion.us) provides a structure for the interviewer or his or her partner to document the family member's answers. It is used to write short descriptions of the child's engagement, independence, and social relationships during each routine. It also provides a scale from 1 to 5 for the interviewer to ask the family how satisfied they are with the routine. Finally, the form lists the five domains on IFSPs, so the team can see what routines provide descriptive information for documenting the child's current level of functioning in those domains. The form serves both as a prompt and a place for documentation but should never be used in a structured-interview manner.

The interviewer reads aloud notes of particular concerns and strengths that arose during the discussion of routines and asks the respondents to decide which of them to work on. This usually generates six to ten "outcomes" or goals. The interviewer asks the family to put the outcomes in order of priority and tells the family what will happen next. Although the steps are important, they are not part of the actual interview. The interviewer alerts the family that the next steps will involve the decisions to be made by the team, resources needed to accomplish goals, and strategies or actions needed to accomplish goals. Other team members also will provide suggestions once early intervention services are begun.

Implications for Intervention Planning and Service Delivery

Weekly home visits have become a default method for delivering early intervention services, and some experts believe that it is appropriate (see Blackman, 1996). The RBI tends to have the following effects on IFSP or IEP development and the provision of services: 1) the family talks more

than professionals do during the meeting; 2) the intervention plan has more specific outcomes than those developed without an RBI; 3) the outcomes are clearly functional for the child and family; 4) the plan is worded in ordinary language with a minimum or lack of jargon; 5) outcomes are not overtly discipline specific, which implies that a generalist or a primary service provider from any discipline could provide support to the family *on the whole plan;* and 6) fewer discrete ongoing service providers are needed; a "consultative," "transdisciplinary," or "primary service provider" model is more feasible. In general, the RBI has important effects on the delivery of early intervention beyond simply asking families what their days are like.

EXAMPLES OF RESOURCE NEEDS DETECTED THROUGH A ROUTINES-BASED INTERVIEW

Two examples of using the RBI to detect families' needs, desires, and priorities are provided next. They show how the process can be applied to assess needs associated with maintaining family routines.

High-Complexity Example

Valerie lived in a homeless shelter while waiting for her boyfriend to get out of jail. She had three children, all with different fathers. Two of the children were enrolled simultaneously in the early intervention system after a referral by the social services agency. Valerie believed she had little choice but to participate in the program because she thought she would lose custody of her children.

I (Interviewer): Valerie, if it's okay by you, I'd like to ask you about your day—how the day goes, what you and the children do, and so on. That way, I'll be able to make sensible suggestions that fit into your daily life. You don't have to tell me anything you don't want to. Is that okay?

V (Valerie): Whatever.

I: When you're done talking about your day, I'll ask you what you want the intervention team to help you with. That way, it will be your decision. Is that okay?

V: Okay.

I: Before we get started, what are your main worries, if any, about Jonquil's development?

V: I don't have any. She's doing great.

I: I know she was tested a week ago. Did that raise any red flags for you?

V: Not really. I can't really remember what they said—I think they said she's behind.

I: Behind in what areas?

V: I don't rightly remember.

I: When they told you those results, were you worried about anything?

V: Not really.

I: Did they say she was different from other children in the way she moves or what her muscle tone is like?

V: They said she's behind in moving because she has several (sic) palsy.

I: They actually mentioned cerebral palsy to you.

V: Yes.

I: Okay, so right now you don't have any major worries about how Jonquil is developing but you have heard she's behind in her moving.

V: Right.

I: All right. As we talk about your daily routines, we'll see whether that makes a difference. So, how does your day start?

V: With one of these young-uns screaming to get out of bed.

I: So you're awakened by kids screaming to get up?

V: Right.

I: Do you have your own room for the four of you at the shelter?

V: Yes, but it don't have no door on it.

I: So the kids' screaming could bother other people.

V: I don't care about them. It's me it bothers.

I: Right. Now, is Jonquil one of the ones screaming?

V: Sometimes.

I: When she's upset, can you tell what it is she wants?

V: Like I said, she wants to get out of the crib. She has to share it with the next one.

The interview proceeded through some early morning routines. The following discussion was about breakfast.

I: What happens next?

V: We get our breakfast.

I: How does that work?

V: Most people go through a line, but we get to sit down at a table and someone brings us our breakfast.

I: Jonquil doesn't sit in a chair, does she?

V: No, of course not. I have her on my lap.

I: Does she sit there okay?

V: No, she gets all stiff and about slides off on to the floor.

I: She gets stiff where?

V: Like her back gets stiff and her legs go straight.

I: Why is that, do you know?

V: 'Cause of the several (sic) palsy.

I: How has cerebral palsy been explained to you?

V: They tried explaining it to me, but I couldn't take it all in.

I: So do you still need some information about cerebral palsy?

V: I reckon.

Later, Valerie said she tried to get out of the shelter for as much of the day as possible.

I: You don't like it in there?
V: Them people are mean.
I: Do you mean the other people staying there or the people who work there?
V: The other ones that stay there.
I: So, in the mornings, after breakfast, you go out with the kids. How does that work for you?
V: It's a pain, dragging three young-uns all over the place.
I: How do you manage it? Do you have a stroller or anything?
V: I've got a halfway broken down old stroller, but that only takes one of the kids. Sometimes I squish two in but then it doesn't roll so good.
I: It sounds like you're always with the kids, in the shelter, out of the shelter, everywhere. Right?
V: Yes. What else am I going to do with them?
I: Do you ever get any time away from them?
V: Sometimes one of the other women will watch them for me while I have a cigarette outside the back door, but I can't be gone for too long.
I: Are you ever able to go out without them?
V: Are you kidding?
I: If we were able to find a way, would that be helpful to you?
V: That would be great, but I don't trust anyone with my kids, so I don't think it's realistic.

As the interview went on, the interviewer had more questions about the housing situation.

I: How long will you stay at the shelter?
V: I don't know. When my boyfriend gets out, we want to find some place to live.
I: Do you have any leads?
V: I don't and I doubt he does. I don't know what we're going to do.

Toward the end of the interview, a new twist came into the story.

I: After the kids are asleep, then what do you do?
V: Hang out with some of the other people.
I: Where? I guess you can't in your room, really.
V: We stand outside, where we can smoke. I can hear the kids or someone comes to tell me if they can hear them.
I: Is this a good time of the day for you, when you get to hang out with some adults?
V: Not really. They drink. They're not supposed to, but they do.
I: And you don't drink?
V: I'm an alcoholic, so I try not to touch the stuff.
I: Are you getting any help with that, or are you doing it on your own?

V: I'm pretty much on my own. My social worker checks up on me but that's mostly to warn me that if I get drunk she'll take away my kids.
I: She actually says that?
V: Pretty much.
I: So do they have programs at the shelter or help you get into an AA group or anything?
V: No, not really.
I: Is that something that might be helpful to you?
V: Yeah, especially if I have to hang around a bunch of drunks.
I: Well, with any luck, you won't have to after a while, but I'll mark it down as an area you might be interested in. Okay?

At the end of the RBI, Valerie chose the following among her priorities:

1. Babysitting
2. Information on cerebral palsy
3. Housing
4. Staying sober

Apparently Low-Complexity Example

Todd and Marissa were interviewed to help them determine intervention priorities for their 4-year-old son who has significant functional limitations related to his autism. These excerpts came from the latter part of the interview.

I (Interviewer): What happens when Todd comes home?
T (Todd): I used to roughhouse with Preston (age 4) and Rachael (age 2) until I got a hernia. Now, I still play with them but in a quieter way.
I (to T): Is that going well?
T: Okay, I guess.
I: What do you do as a group? You had mentioned that you aren't as active right now as you used to be.
T: I still play with them a lot.
I: So, when you get home, do you take the children right away and do something with them?

Todd and Marissa look at each other.

M (Marissa): Well, eventually.
T: Sometimes it takes a while to unload my stuff and such, but the kids come running up to me right away.
I: Okay, so you have the kids, Todd. Marissa, is this finally a break for you, or is it that you now have a third person to attend to?
M: It's that I have a third person.
I: Okay, I'll come back to that. Todd, what do you and the kids do?

T: We go out in the yard, maybe read a book if the weather is not good. But they like to do more active stuff than that. So, it's kind of hard not being able to rough around with them.
I: So, right now it's hard to keep them entertained as well as you used to because you're recovering from the hernia operation?
T: Right.
I: When you play with the kids at this time, what does Preston do? How does he play with you?
T: He'll jump on my back or push me and then run away, wanting me to chase him.
I: Does he use any words when he does this?
T: Not really. Even though he knows how to say a lot of words, when we ask him, "What's this?" he doesn't use them when he's playing with me like this.
I: Okay, and what about his movements? Is he coordinated, clumsy? How would you describe the way he moves around?
T: He's completely coordinated—at least as much as I'd expect out of a 4-year-old.
I: So he jumps around, pushes, runs, and so on?
T: Right.
I: When you do something with Rachael, what does he do?
T: Sometimes, he acts jealous, like he pushes me or pulls on my shirt or my hand. Sometimes, he just skips off and wanders around the room ignoring us.
I: Does he ever join the two of you?
T: Sometimes it's all three of us rolling around on the floor.
I: Okay, so he will join in at times, perhaps when he's sort of tricked by the momentum of the game?
T: Yeah, that's it. If I try to get him involved in some activity with Rachael, like reading a book, he'll resist.

Because this gave a reasonable picture of Preston's engagement, independence, and social relationships during this play time with Dad, the interviewer moved to the satisfaction question.

I: Is this a good time of day for you?
T: Yeah, it's pretty good. The kids are usually in a good mood.
I: But it's just *pretty* good.
T: It's not exactly like it's my down time after I've been going hard at work. It's not like I can walk in the door and put my feet up.
I: That would be nice, wouldn't it?
T: Yeah, but totally unrealistic.
I: Marissa, what are you doing while Todd's playing with the children?

M: He's not always playing with the children. Sometimes he needs to tell me something about his day at work, or I need to tell him something about my day or the kids. We try to wait until later, but. . . .
I: Okay, so sometimes you two have some catching up to do. What are the kids doing in the meantime?
M: Going nuts, trying to play with Daddy. It's not like we can really have good conversations at this time.
I: So, it sounds as though this transition time, when Todd comes home in the evening, isn't exactly satisfactory for either one of you.
M: True.
T: True.

The first discussion about Preston at mealtime came up when discussing dinner because during the week Preston eats both breakfast and lunch at preschool.

I: How does dinnertime go?
M: We eat in shifts—the kids first and us later.
I: Is that how you want to do it or is that just the only way you've been able to manage to do it?
M: That's the only way we really can do it, so it's how we want to do it.
I: Fair enough. So Preston and Rachael eat first. Do they eat the same thing at the same time?
M: Well, there's a problem there. Preston will eat only Italian—spaghetti, lasagna, ravioli.
I: Can you get him to eat anything with those—any vegetables, for example?
M: Not really. Sometimes, if I actually cook those things instead of getting them out of a can, I can cook in some vegetables, but that isn't too often.
I: You said this was a problem. What is the problem?
M: It's just not enough variety.
I: Do you mean for his diet or because it's just weird not to eat a greater variety?
T: It's weird.
M: Yeah, weird.
I: What happens when you do try to get him to eat something else?
M: He refuses and he will get mad and throw a fit if we try to get pushy.
T: But we don't want meals to become a battleground.
I: Very wise, but I am correct, am I not, that you would like Preston to take in a greater variety of foods?
M: That's correct.
I: Who have you talked to about this so far?
M: No one. I've talked to the teachers about it. At school, he'll eat cereal in

the morning and nothing but Italian at lunch. I have to send cans for them to keep there.

I: What about the pediatrician or any other health care person? Anyone talked to you about this?

M: No.

I: A nutritionist?

M: No, do you think he needs to see one?

I: I don't know yet. Let's see what we end up with as your plan of action and then see what professionals would be necessary to get that plan accomplished.

M: Okay.

Later in the interview, the interviewer asked what happens after the children go to bed.

M: That's when he and I have our dinner.

I: So is this a time where you can catch up with each other if you couldn't talk earlier?

M: Right.

I: Do you have other opportunities for just the two of you?

M: No, not really.

I: Is that okay?

M: I would like to be able to go out.

I: Do you mean by yourself or with Todd?

M: Both.

I: Todd, how about you?

T: I have my time to myself at work, but I'd like to be able to go out with Marissa.

I: What about her going out by herself, without the kids?

T: That would be good for her. She doesn't have any time to herself.

I: So, why doesn't this happen right now?

M: There's no one to keep the kids—well, Preston. Todd's father and stepmother are in town, but they're no good with Preston.

I: Do you know any babysitters, neighborhood kids, or whomever?

M: No, none who would understand how to deal with Preston.

I: Has anyone mentioned respite to you?

M: No, what's that?

During the recapitulation of the interview, the interviewer included reminders that Marissa and Todd had talked about the need for down time for one or both of them during the hours from hell, about their desire to know more about Preston's diet, and about their desires to go out. Other goals were established, but at the end of the RBI, Marissa and Todd chose the following among their priorities:

1. Parents will go out together without children.
2. Marissa will have 2 hours to herself every week.

3. Preston will eat greater variety of foods than Italian—and his parents will get information on nutrition.
4. Todd will have one down time after work per week, and Marissa will have one down time during the day per week.

CONCLUSION

Discovering a family's assets, including family routines, has become a critical part of the early intervention enterprise. Professionals have many ways to gain this information, ranging from informal conversations, to semi-structured or structured interviews, to questionnaires. This chapter provides a model for integrating the assessment of family routines into the overall assessment and intervention planning process. Even though legislation has been used, principally through the IFSP, to prompt professionals to determine families' concerns, priorities, and resources, too often this information is simply assessed and listed, with little connection to the rest of the early intervention activities. By assessing resources in the context of daily routines, the information is likely to be used. Indeed, the RBI always ends with a list of family-directed outcomes or goals. The connection from resource assessment to intervention is tangible. The resources that families need to accomplish their priorities by maintaining or enhancing their routines can be directly derived from the interview. Most important, the resources are being applied to the attainment of meaningful goals.

The first scenario gives a somewhat extreme example of the importance of assessing resource needs in the family's context. It also shows the importance of using a personal approach to the assessment. If Valerie had been handed a form to complete, then it is possible she would not have completed it or would not have been truthful. Her list of resource needs is all about information, but three of the needs—babysitting, housing, and staying sober—are likely to require considerable follow-through.

The second scenario shows 1) how important it is to establish a relationship with the family while assessing resources related to routines, 2) how specific services are not identified until after outcomes are decided (i.e., the nutritionist), and 3) the blending of parent and child needs into the single intervention plan. An important note about the difference between resources and services needs to be made. When Preston's family asked about a nutritionist, the interviewer correctly deferred the recommendation until the outcomes were decided. If a family goes into the assessment process with a view to obtain a specific service (e.g., physical therapy) but without a clear idea of why, then the team should gently refocus the discussion to the desired outcome (i.e., goal) first. Finally, the interview with Preston's family shows how an RBI can produce meaningful family outcomes. Early interventionists are effective in determining child-level

outcomes but less so in determining family-level ones; this process can help balance the outcomes. This balance is important as soon as one understands the reciprocal relationship between family and child needs.

Assessing families' resource needs is, therefore, vital, not only because the resources might be important for the child's and family's development but also because the process of identifying the needs and implementing them can be the platform for a family-centered approach to early intervention. The more we help families with their resources and their routines, the more we help families in general.

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