TECSNews— For the Allied eHealth Resource Network

Special points of interest:

- Providing services differently
- Supporting children with autism
- A SC family's perspective
- Resources for providers & families
- Important news & updates

Providing Early Intervention (EI) - what are other states doing, and what does the evidence say?

Forty-four percent of families participating in early intervention systems continue to receive services focusing primarily on the child (according to the National Early Intervention Longitudinal Study, NEILS, a study that is part of a series of longitudinal studies funded by the U.S. Department of Education; visit http://www.sri.com/neils/). The study described this finding as *"concerning"* because it is contrary to current recommended practice in early intervention (EI)— which is to "work with the parent on how to support the child's development so that optimal and/or therapeutic interactions can be incorporated into the child's daily activities."

NEILS investigators note that further research is needed to determine if the other 55% of families, who stated that professionals focused on them and their child, received services consistent with recommended practice. An earlier NEILS report also found that *most states usually provide services with the child during beginning months* in the EI system, and then gradually change to sessions that primarily focus on consultation with caregivers (or integrated services).

> *Services should focus on supporting families and others in the child's life...*
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> *Read more about what IFSP services should look like on p. 2 & IEP services on p. 5*

Many of the sessions at the 2008 SC Early Intervention (EI) Conference elaborated on the issue that EI services differ from traditional interventions. For example, Dr. Joicey Hurth noted that the main goal of early intervention services is to prepare a child to function or take part in activities that are of concern and priority to the family (which may involve learning specific skills related to that function), not to primarily develop skills in deficit areas.

Also at the conference, Dr. Robin McWilliam pointed out that integrated services which impact daily interactions with a child contribute more to a child's progress than do continued individual sessions. IFSP goals and objectives should be selected by a child's function or participatory needs, and not necessarily by developmental level.

So what should services look like, and how can we provide them differently?

About this issue

This issue spotlights *current recommended practices for increasing competence of both child & family,* using a family & routines-based approach. It includes information provided by researchers & specialists in early intervention & related fields, the 2008 SC Early Intervention Conference, professional associations, other states, & South Carolina.

Articles feature ways to design services differently, access and implement assistive technology methods, & support children with autism. This issue also includes information for providers and families related to BabyNet contract require-ments, and helpful resources, including intervention strategies shared by a therapy provider. Finally, *be sure to read interesting insights from a parent on p. 13.*

Note new topics to be included in the newsletter— professional association activities, & new AT products & related information.

What should early intervention services look like? *Continued from page 1*

Service delivery issues become even more important when we consider tightening budgets and shortages of intervention specialists. It has become increasingly necessary for teams to learn about and implement the best evidence-based recommendations available to-date and to do so in a way that is cost-effective (McWilliam, 2008 EI Conference).

To begin taking a closer look at how teams should plan and provide services and supports, the following information from the 2008 conference session presented by Joicey Hurth is included below for all team members to consider.

Abbreviated from: Workgroup on Principles and Practices in Natural Environments, February 2008, Agreed upon practices for providing services in natural environments. OSEP TA Community of Practice—Part C Settings

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Principle: Infants and toddlers learn best through every day experiences and interactions with familiar people in familiar contexts.

Looks like	Does not look like
Helping families understand how their toys and materials can be used or adapted	Using professionals' toys, materials or equipment because these are necessary for child progress
Identifying activities the child and family like to do which build on their strengths and interests	Designing activities for a child that focus on skill deficits or are not functional or enjoyable
Focusing intervention on caregivers' ability to promote the child's participation in naturally occurring, developmentally appropriate activities with peers and family members	Conducting sessions or activities that isolate the child from peers, family members, or naturally occurring activities

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Principle: The primary role of service providers in early intervention is to work with and support the family members and caregivers in a child's life.

Looks like	Does not look like
Providing information, materials and emotional support to enhance families' natural role to foster their child's learning and development	Training families to be "mini" therapists or interventionists
Discussing with families what they want to do & enjoy doing, & family routines and activities that will support desired outcomes; continually acknowledging the many things families do to support their child; &	Showing strategies or activities to families that professionals have planned and then asking families to fit these into routines
Allowing families to determine success based on how they feel about the learning opportunities and activities the child/family have chosen	Basing success on the child's ability to perform assigned activities and parent's compliance with prescribed activities

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Principle: IFSP goals must be functional and based on children's and families' needs and priorities.

Looks like	Does not look like
Writing IFSP goals based on families' concerns, resources, and priorities	Writing IFSP goals based on other test results
Writing functional goals that result in functional support and intervention aimed at advancing children's engagement, independence, and social relationships	Writing IFSP goals focused on remediating developmental deficits
Having goals and objectives that build on a child's natural motivations to learn and do; match family priorities; strengthen naturally occurring routines; and enhance learning opportunities and enjoyment	Having goals and objectives that focus on deficits and problems to be fixed

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This information was taken from Seven Key Principles of Early Intervention, validated through several research, model demonstration, and outreach projects. For more information, go to http://www.nectac.org/topics/families/families.asp.

Visit the TECS website http://uscm.med.sc.edu/tecs/ for all handouts and resources from the 2008 conference.
Also see   http://www.dec-sped.org/recommendedpractices.html and http://www.dec-sped.org/pdf/recommendedpractices/PDI%206%2010%2007.pdf for practices recommended by the Division for Early Childhood, which bases its recommendations from input from a variety of fields.

A Framework for Providing Family-Based Services and Supports in Early Intervention

From TaCTICS—Therapists as Collaborative Team Members for Infant/Toddler Community Services, an outreach project funded by OSEP to deliver training and follow-up assistance to teams of service providers working in early intervention (http://tactics.fsu.edu/)

Information to know

An important component of early intervention is to increase the competence of *both the child and caregiver*, **using a family and routines-based approach (McWilliam, 2008 Early Intervention Conference).** The key to success is "for the family to guide the intervention process by identifying procedures and strategies that **'match'** their own and their child's learning style within the routine" (see TaCTICS training modules at http://tactics.fsu.edu/ for more information). Interventionists help "guide, inform, and encourage the caregiver and child in interactions," without "taking over" or providing traditional "hands-on" intervention.

In this "triadic" (provider-caregiver-child) framework, **the role of the caregiver is to embed the child's IFSP goals during preferred daily routines. The role of interventionists is to interact with the child and caregiver; specifically, to:**
- ☑ recognize and expand on child and caregiver strengths
- ☑ use actions and statements that are responsive to their strengths and preferences and
- ☑ model or suggest strategies to increase the competence of both child and caregiver.

The following is a review of a few specific techniques, with examples, that intervention-ists use to implement family-based services and supports (i.e., integrated services). They are based on products from the TaCTICS website, which offers numerous resources and references that are "empirically validated...for use within family-guided routines….".

Establish a Supportive Environment (this prerequisite increases the probability of positive interactions):

✻ **Observe caregiver-child interactions** in routine activities so that you can contribute and plan effectively

✻ **Together select activities and materials of interest, positions that encourage comfortable and positive interactions, and modifications to position and materials**, to increase success or satisfaction.

✻ **Position yourself to focus on the caregiver and child**, to support interaction between them (such as with caregiver at eye-level, face-to-face with the child, and comfortable, and interventionist beside the caregiver or behind the child, to lend physical or verbal assistance as needed, etc.)

✻ **Help caregivers see their role and value to the child in the interaction,** such as by commenting on the child's enjoyment and engagement in their interaction. Use strategies, such as ones that follow on this page and the next, to enhance caregiver competence and confidence

Enhance Caregivers' Competence and Confidence (use strategies to recognize and expand behaviors of caregivers; this enhances caregivers' competence, increases the likelihood that learning opportunities will occur often, and respects the uniqueness of each caregiver and child):

✻ **Recognize and reinforce strategies the caregiver already uses to facilitate their child's development**, such as facial expressions that encourage responses, pausing, gesture cues, labeling, repetition, etc.; e.g., "You called the sock 'a sock' when you were putting it on. Naming common items as you use them really helps Cody learn words." "He looks like he's using his eyes to tell you he wants more when you hold up the juice. Your facial expressions and pausing help him communicate." "Did you realize you were creating another opportunity for Keith to practice walking on different surfaces when he played in the grass?"

✻ Remember to use adult learning principles when supporting caregiver-child interactions. **Use caregivers' ideas and expand**; e.g., "Your suggestion to play piano is great. If Brad stands by it with you, he can play and practice standing at the same time." "That's a great idea for Tami to practice sitting when you and your husband go shopping. Since she loves to shop with you, you might even be able to practice having her reach over to get an item like you do when you play."

A Framework for Implementing Family-Based Services and Supports
based on information from TaTICS

Provide Information (many people equate "teaching" with a directive style; with enough information, caregivers and interventionists can understand, learn, make decisions, and participate best)

✮ **Reinforce caregiver's actions with specific information**; e.g., "Ted smiled and looked at you. He was telling you he likes the way you brushed his cheek." "You combed Dolly's hair like Sally did. That encouraged her to imitate you."

✮ **Provide information by sharing specific developmental milestones or giving enough explanation**; e.g., "Most children begin sitting with hands on the floor for support." "When you look at Arianna and pause, you're telling her you want her to respond, to take a turn." "Using shorter sentences when you talked to Maddy helped her understand what to do. It's easier to attend to fewer key words, and slowly we can add more."

✮ **Explain and expand on strategies for the caregiver to use**; e.g., "Pausing seemed to encourage Haley to use her words. It usually works best when you pause or wait for at least 5 seconds for her to respond. This is also called 'time delay.' At childcare, they also use 'wait time.'" "Tim really pays attention when playing with the puzzle. Since children do better with activities they like, do you want to have him choose the next puzzle, or the puzzle pieces? Is there another favorite toy you'd like to try this with?"

✮ **Point out aspects of the child's performance and interpret their significance**; e.g., "See how easy climbing up the slide stairs is when you stand behind Tommy. You are there if he needs support, but you let him be independent." "He communicated a lot today. I thought he pulled your hand more and looked at you a lot. What do you think helped him communicate more?"

Increasingly facilitate caregivers' abilities to enhance specific child skills during interactions (especially when introducing new concepts or specific strategies, caregivers appreciate various learning opportunities such as demonstration and practice)

✮ **Model and demonstrate strategies to use**; e.g., "Look Mom. Arianna and I pop bubbles with our feet. Now our elbow. Now face." Show a strategy, problem-solve together to improve the child's progress, and ask for caregivers' ideas.

✮ **Offer caregivers choices of strategies**; e.g., "You can hold Mac's arm right above the elbow from behind or at the side. Which would be most comfortable for you?" Don't be tempted to offer caregivers many strategies, too quickly.

✮ **Give specific suggestions, along with explanations**; e.g., "Arianna likes bubbles. Let's see if she'll communicate a choice between bubbles and that toy she doesn't seem to like. This way she might reach for her choice more easily." "Since you both like playing the piano, let her sit on your lap for awhile and play so she won't tire as easily. This way she can keep practicing; you might also get her to vocalize a request for more by stopping and waiting."

✮ As caregivers are interested, **offer supporting information or resources** that are short, understandable, and easy to follow, such as booklets or videos.

✮ **Together reflect on where the child is now**. Discuss progress the child has made relative to his IFSP goal, the strategies that are helping, other strategies both of you may want to try, etc.

What do you think about current early intervention issues?

INFORMATION FROM AROUND THE STATE

Children with Autism Spectrum Disorders (ASD)— getting ready to go to school...

Information to Know for all early intervention team members!

Transitioning From Home to School-based Services— How does the family fit in, for children with ASD?

By Tim Conroy, Vice President, The SC Autism Society (SCAS)
http://www.scautism.org/

There is no single approach or intervention that works best for all students with Autism Spectrum Disorders (ASD) (Dunlap & Fox, 2002). Instead, instructional approaches must be tailored to meet the unique individual needs, talents, and family characteristics of each student.

It has been well documented that Individualized Education Program (IEP) teams cannot adequately meet the needs of students with ASD without meaningfully sharing and collaborating with parents. When children get to the classroom, they work with teachers and experts who specialize in ASD. But, it is important to remember that parents will continue to be the expert on their child, with valuable information to share. When families are involved, students with ASD can benefit from the general education curriculum.

> The vision and promise of the IEP is the sharing of information and commitment among all team members, including the family.

From time to time, it is important for team members at the IEP table to review why collaboration with families is vital to promoting the competence, independence, and satisfaction of students (see information below). There is no more critical period to stress this reminder than at transition planning conference meetings. With meaningful collaboration, IEPs for children with ASD can be developed effectively and implemented *by age three*. **The South Carolina Autism Society's Parent School Partnership Program was designed to build ongoing collaboration between parents and schools, recognizing that each is an essential partner in the child's education.**

What the Evidence Says about the Role of the IEP Team and Family Involvement in the Schools— a resource guide for team members

The importance of teams collaborating and sharing with parents has been so extensively supported by research that it is no longer considered an option, but a professional obligation (Corrigan & Bishop, 1997). Dunlap (1999) states that family members are the most stable, influential, and valuable people in a child's life. Because family members know their child best, spend the most time with him or her, and have an immense influence on their child, it is critical that they are active participants in developing and implementing their child's educational programming and are considered valuable members of the IEP team.

Another important reason to actively involve parents in their child's education is because of the problems that students with ASD confront in generalizing skills learned in one environment (e.g., school) to other environments (e.g., home). School and family collaboration contribute to intervention effectiveness, especially when strategies are used across multiple environments. Indeed, implementing the same strategy across multiple environments and multiple social partners can greatly enhance the likelihood of generalization (Drasgow, Halle, & Ostrosky, 1998).

A critical role of IEP teams is to ensure that parents share their insights— of their child's interests, motivators, preferences, skills, choices, needs, actions, stressors, behaviors, etc. In this way, education for students with ASD is designed for success, not failure. **The South Carolina Autism Society (SCAS) strives to facilitate this by providing:**

1. Information and training from a parent's perspective about autism spectrum disorders to families and schools,

2. Providing a parent mentor to assist the family in understanding their role on the Individual Education Team, and

3. Serving as a resource for schools and families.

For additional information about the SCAS's Parent School Partnership Program, techniques for collaboration, references and resources, or other assistance, please contact SCAS at:
806 12th Street, West Columbia, SC 29169
1-800-438-4790 or 803-750-6988

INFORMATION FROM AROUND THE STATE

Augmentative Communication Technology for Providers and Consumers in Rural Settings
By Dr. Harriette Gregg and Mrs. Debra Frishberg

South Carolina State University Speech Pathology and Audiology Program has received funding to expand knowledge and practical experiences related to assistive technology/augmentative communication. Dr. Harriette Gregg and Mrs. Debra Frishberg are Co-Directors of this three-year project – Project ACT.

Project ACT—Augmentative Communication Technology for Providers and Consumers in Rural Settings:

This project is designed to increase the number of highly qualified Speech-Language Pathologists (SLPs) working with potential AAC/AT users in public schools and other settings in rural areas of SC. In order to improve outcomes for children and adults with disabilities and their families, this project will enhance and expand service delivery by introducing and providing access to appropriate assistive technology and related intervention strategies.

Specifically, this project will expand the capacity of the SCSU speech-language pathology programs to add cutting edge, research based AAC/AT instructional modules and a clinical learning lab available to students, providers, families, and others working with children and adults with language, speech, and communication needs. SLPs are the professionals considered to be best qualified and ultimately responsible for evaluating, executing, and coordinating communication strategies for children and adults needing AAC/AT assistance (Silverman, 1995). A particular expertise is needed to adequately provide augmentative communication evaluations and strategies for the diverse range of abilities exhibited by potential consumers, particularly in rural areas where access is typically limited.

According to a 1991 report from the Committee on Augmentative Communication of the American Speech-Language-Hearing Association (ASHA), highly qualified personnel are those who conduct appropriate and comprehensive evaluations. AAC assessments should involve input from families and other team members, including "physical, sensory, emotional, cognitive and educational performance, speech and language skills, auditory skills, correct seating and positioning, general communication

skills, and communication needs for social, emotional, educational, and/or vocational purposes" (ASHA, 1991).

Not only must personnel be competent in selecting and developing effective AAC systems, they must also have access to recommended intervention practices. SLP providers must offer the child and family strategies to enable "effective utilization of the techniques and symbol systems for the achievement of communicative competence as defined by the individual and the message receiving community" (ASHA, 1991). Follow-up and on-going evaluations are also critical for successful implementation of AAC methods.

Highly qualified personnel/speech-language pathologists can address concerns and dispel myths that surround delivery of AAC/AT services. For example, there is often a concern regarding the amount of time and documentation that may be required to justify selection and use of assistive technology or augmentative communication. Team members and families have concerns about the role they must play in daily settings to integrate and facilitate the use of augmentative/alternative communication strategies. Some persons may think that AAC/AT is an impediment to developing speech, or that use of AAC/AT signals that professionals have given up on improving or developing speech skills (Silverman, 1995). *Therapists who are specifically trained and/or have access to critical resources are able to correct these misconceptions and offer appropriate and cost effective options to meet the needs of children and adults with speech, language and communication needs and their families.*

New personnel preparation grant awarded to expand community-based information and competency in AAC, in rural SC areas.

INFORMATION FROM AROUND THE STATE
Augmentative Communication Technology for Providers and Consumers in Rural Settings

It is important that SLPs who are responsible for augmentative communication intervention receive the same level of intense instruction and clinical training, the same scope and depth of training, which is commonplace for other areas of communication disorders. In general, within the last decade, communication sciences and disorders educational preparation and training programs have increased exposure to the field of AAC/AT. However, not all programs have provided sufficient training to produce highly qualified personnel to address communication needs of students in public schools (ASHA, 1991). ASHA committee reports (1998) and the 2002 Omnibus Survey Reports continue to support the notion that highly qualified public school personnel are sorely needed to use evidence-based practices when they provide AAC/AT services.

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Addressing needs of providers, beginning with school-based personnel:

During the 1999-2000 academic year, a survey of South Carolina school-based SLPs was conducted. Responses were analyzed from 479 out of 716 SLPs (67%) in 66 of the 86 South Carolina school districts. Of the 472 respondents who answered the question, *How well did your academic program prepare you to assess and implement AAC?"* only 11% indicated that they were very well prepared. The remaining respondents indicated that they were somewhat prepared or that they were not at all prepared. An overwhelming 94% of respondents indicated that future speech-language pathologists should be required to take an AAC course before graduating (Sandifer, 2000, SCSU SPA masters thesis).

While this survey provided information from the perspective of public school SLPs, there is a need to expand this information from the perspective of other team members, such as classroom teachers and other health care professionals who may interact with AAC/AT users or potential users; surveys would target information such as, awareness of the types of and function of AAC/AT systems, understanding the individual with special needs who would be a potential AAC/AT user, preparation as a supportive communication partner, prior training including university courses and seminars, competency in the use of AAC/AT equipment, and barriers to AAC/AT use. Feedback from surveys of personnel in a variety of rural settings that is incorporated into instructional and clinical experiences serve as empirical evidence for components to be included in **Project ACT** instructional modules.

For more information about this project, please contact:

Project ACT Clinical Learning Laboratory—South Carolina State University
Speech-Language-Hearing Clinic

Telephone: 803-536-7237 or 803-536-8073.

INFORMATION FROM AROUND THE STATE

Occupational Therapy Using the Sensory Integration Treatment Approach at Home
By Tami Lawrence, M.S., OTR/L

As we hear the buzzwords of *evidence-based practice* and *family-centered practice* so frequently, occupational therapists using the sensory integration frame of reference will be encouraged by contributions in the literature that support this treatment approach (Case-Smith & Bryan, 1999; Miller, Coll, & Schoen, 2007; Miller, Schoen, James, & Schaaf, 2007; Young, 2006). Many pediatric OTs use a sensory integration frame of reference (OT-SI); in fact, most OTs practicing in pediatrics identify this as the primary theory guiding their practice. Yet, traditional OT-SI or Ayres' Sensory Integration© often occurs in an SI clinic, with the requisite suspended equipment, mats, balls, and climbing opportunities. *So, how does this approach transfer to the home setting for early intervention?*

Many of us have created what we thought was the "perfect" home program, trained the parent in this simple program, and then watched as it collects dust, or worse yet, gets "lost." This example of an exercise in frustration speaks to the importance of family-centered, versus child-centered therapy. *While barriers may exist* (Edwards, Millard, Praskac, & Wisniewski, 2003), *it is quite possible to implement family-centered strategies using OT-SI.* The key appears to be finding ways of expanding family participation to promote integration into everyday activities (Edwards et al., 2003; Schultz-Krohn & Cara, 1999). This entails looking beyond the parent and seeking other participants to support carryover. Older siblings, aunts or uncles, as well as other healthcare professionals can also participate in therapeutic occupations with the child.

What follows is a brief overview of home-based strategies that address each sensory system. As you review these, consider the children you work with. A great deal of literature identifies *sensory processing differences* in young children (Desantis, Coster, Bigsby & Lester, 2004; Rogers, Hepburn, Wehner, 2003; Weatherston, Ribaudo & Glovak, 2002). It is possible that you work with infants or toddlers who have sensory modulation challenges. Some may be over-responsive to some forms of sensory information, such as bright daylight, loud sounds, or light touch. Others may be under-responsive, requiring more intense and alerting sensory information to help their nervous systems achieve an optimal state of arousal. A key concept involves modifying any or all of the following factors: environment (including people in the child's natural environment), the child, and the occupation or expected task.

The examples that follow apply to the child who does not register sensory information (low arousal). They are designed to *increase* the child's level of arousal in everyday activities:

	Bathtime	Dressing	Feeding	Playing
Auditory:	Play upbeat music and sing during bath	Talk through/ describe the dressing process	Provide upbeat background music	Use toys that make sounds; play lively background music
Taste/smell:	Blow bubbles; use scented soaps (citrus, mint)	Use scented lotions	Add new aromas to food	Use scented toys/ clean toys with scented cleaners
Tactile:	Rough & textured washcloths & towels; use textured toys and soap (crayons on arms & legs)	Rub lotion before dressing; provide clothing with different textures	Introduce diverse and textured food options	Play on different surfaces (grass, linoleum, carpet); provide toys with varying textures/ add textures to toys
Movement: (Vestibular/ Proprioceptive)	Encourage splashing/ spraying with toys; place toys out of reach	Move each body part as it is dressed; have child retrieve socks, shirt, etc.	Encourage child to participate by carrying cup/utensils to table	Place toys out of reach; use toys that encourage movement (rolling balls, wheels, etc.)
Visual:	Use soap crayons to draw on tub and/or body; adjust lighting in bathroom	Choose bright and contrasting colors.	Use brightly colored foods; use contrasting plate so food is easily visible	Select brightly colored toys; use mirrors at eye level

Table 1. Adapted from Dunn (2007)

Sensory Integration at Home, continued from page 8

Within each family, therapists will assess and determine the appropriateness of strategies such as those described above. In addition to skilled clinical observations, the advent of assessment tools such as the Infant Toddler Sensory Profile (Dunn, 2002) provides therapists with in-depth information regarding sensory processing challenges. With a better understanding of the child's sensory processing abilities, therapists can create effective and family-centered intervention strategies for everyday life occupations.

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Resources

The SPD Foundation http://www.spdfoundation.net/

Provides resources, research and advocacy information.

Sensory Integration Global Network (SIGN): http://www.siglobalnetwork.org/index.html

Research, resources and information regarding Ayres Sensory Integration©

Library Resources for Providers and Families!

CDR Library Resources

By Steve Wilson, Coordinator, The Center for Disability Resources Library

The Center for Disability Resources (CDR) Library is the largest collection of its kind in the Southeastern United States. *The library is a collaborative effort between BabyNet, the Center for Disability Resources, the SC Department of Disabilities and Special Needs, and the University of South Carolina (USC) School of Medicine Library.*

It is located within the USC School of Medicine Library on Garners Ferry Road. *Designed to aid the information needs of families, faculty, students, staff, and other professionals working with individuals with   disabilities*, the Center for Disability Resources Library consists of over 5,300 books, videos, brochures, and audiotapes, covering a variety of disability-related topics. The library's website provides access to an online catalog of library materials and directs users to high quality disability information websites. Visit the website at: http://uscm.med.sc.edu/CDR/index.htm.

LIBRARY SERVICES FOR YOU!

✯ **Anyone living in fifty states can check out library materials.**

✯ **Requests for information are accepted by mail, phone, e-mail, fax, and in person.**

✯ **Books may be borrowed for a month. Videos may be borrowed for 2 weeks.**

✯ **Too busy to visit the library in person? Library materials and information can be mailed to your home or office.**

✯ **When materials are mailed to you, postage-paid return mailers are available for materials sent to South Carolina families.**

✯ **Residents of all other states may check out one item at a time and are responsible for return postage.**

✯ **A monthly list of new resources is distributed to library patrons by e-mail or mail.**

To use the library's services

Contact: Steve Wilson

Phone: (803) 733 - 1501
E-mail: wilsons@gw.med.sc.edu
Fax: (803) 733-1509

Mailing Address: Center for Disability Resources Library
School of Medicine Library
University of South Carolina
Columbia, SC 29208

The Story on Early Literacy in Early Intervention Practice

By Suzan Albright, TECS Technical Assistance Specialist

Once upon a time, when you were very young, you became a literate person! Do you know how old you were when you first learned to read and write? Do you know how old you were when you started to learn the basics that enabled you to become a person who can read and write?

The *fundamental knowledge and skills* that enable children to learn to read, write and communicate are known as *early literacy skills* (Masiello, 2007; Zero to Three, 2003). Learning them begins in infancy!

What are the top 5 reasons to address Early Literacy Learning within the context of BabyNet service delivery?

1. **Evidence** - Research indicates that the process of learning spoken and written language begins in early infancy. The process involves early childhood experiences with a variety of print materials and interactions between children and their adult caregivers (Masiello, 2007; Zero to Three, 2007).

2. **Prevention** - Children with disabilities are at increased risk for struggling with reading and language activities in school.

3. **Law** - Part C of the Individuals with Disabilities Education Act of 2004 specifies that IFSP content must include outcomes that address "pre-literacy and language skills" (Individuals with Disabilities Education Act of 2004, Sec. 636 (d)(3)).

4. **OSEP requirements** - The Office of Special Education Programs (OSEP) requires reporting of Child Outcomes for children who receive Part C early intervention services. One of those Child Outcomes is "Acquisition and use of knowledge and skills (including early language, communication and literacy) (Individuals with Disabilities Education Improvement Act, 2004).

5. **School readiness guidelines** - South Carolina's school readiness guidelines for preschool age children include early literacy and specifically address issues related to children with different needs and abilities (South Carolina Department of Education).

Addressing early literacy within the framework of early intervention service delivery is a responsibility of *all* service providers who are involved in developing and implementing the IFSP along with families. Both service providers *and* families need access to information that helps them learn how to include evidence-based early literacy learning within family routines, activities and places.
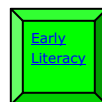
Here are two informational sources to which you can refer:

[The Center for Early Literacy Learning (CELL)](#) was recently established through funding from the U.S. Department of Education, Office of Special Education Programs to promote adoption and use of evidence-based early literacy learning practices by providers in both Part B and Part C early childhood programs. You can locate a variety of products for parents and early intervention service providers at their website.

[The Annotated Index of Online Resources for Special Instruction](#) is a feature of the TECS website which provides links to online resources that are free and easy to download. Many of the resources are available in multiple languages, and some include video vignettes. Over 30 items in the index are specific to early literacy. To access them, just click on the topic Early Literacy. **TECS website products such as this are for everyone to use.**

Visit one of many sites with ideas for early literacy → Early Literacy

So, do a little reading, and see how easy it will be to make early literacy learning a part of *your* evidence-based practice, happily ever after!

References:

Center for Early Literacy Learning (CELL) http://www.earlyliteracylearning.org/.

Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. § 1400 *et seq., 2004*.

Masiello, T. L. (2007). Early literacy can be promoted through experiences with print and language. CELLnotes, 6 (1). Center for Early Literacy Learning. Available 15 May 2008 15 May 2008: http://www.earlyliteracylearning.org/cellpapers/cellnotes_v1_n1.pdf

South Carolina's School Readiness Guidelines for 3,4, and 5 Year-Old Children, Good Start Grow Smart Collaborative Partnership, Office of Early Childhood Education, SC Department of Education. Available from the South Carolina Department of Social Services, Child Care Services 15 May 2008: http://childcare.sc.gov/main/docs/gsgs_finalbook_022608.pdf

Zero to Three (2003) What We Know About Early Language and Literacy Development. Available 15 May 2008: http://www.zerotothree.org/site/DocServer/earlyliteracy2pagehandout.pdf?docID=2681&AddInterest=1145

More Assistive Technology Information and Resources!

The Power of Two: Making Choices Using Single-Message Communication Devices

Children who are beginning communicators learn that making choices is a powerful thing. Choices can be communicated with different types of single-message voice output devices. These devices include the LittleMack and BigMack from AbleNet, Inc., the Partner One from AMDi, and the Chipper from Adaptivation. No matter which device you choose, giving a child a single device may seem like a good place to start with teaching communication skills. However, using one device means the adult has made the only choice available to the child. Consider the advantages of providing two single-message communication devices. Most children find this arrangement very motivating and empowering. It also encourages the child to attend and actively participate in changing their environment.

Two single-message communication devices can be programmed different ways to increase the child's motivation to participate:

- ❑ Put a symbol and related recorded message of a favorite thing on each device.
- ❑ Put a symbol and related recorded message of a favorite thing on one device and put a symbol and related recorded message of a least favorite thing on the other device.
- ❑ Put a symbol and related recorded message of a favorite thing on one device and use the other device without a symbol or a recorded message.

Make sure you provide multiple opportunities for the child to make choices throughout the day. See the examples below for incorporating choices during daily routines, including physical, occupational or speech therapy, or special instruction activities. Here are just a few examples of choice making:

Try this
- with and without voice output
- with objects or pictures

- Food and drink (Goldfish or Pretzels)
- Toys (Barney or Tigger)
- Game Activities (Ball or Computer Games)
- Everyday Activities (Brush Teeth or Comb Hair first)
- Places (Dollar Store or Wal-Mart)
- Materials (Markers or Crayons)
- Clothing (Red Shirt or Blue Shirt)
- Actions (Walk or Run)
- People (Grandma or Grandpa)
- Feelings (Happy or Sad)
- Songs (Old MacDonald or Wheels on the Bus)

It's quick and easy to change messages on single-message communication devices. This allows for multiple choice making opportunities during a single activity. For example, you can ask "Do you want to play bubbles or blocks?" (The child answers "blocks"), "Do you want big blocks or little blocks?" (The child answers "little"), "Do you want to build a house or a bridge?" (The child answers "house"), "Do you want a big house or a little house?" You will think of lots of other ways to help a child make choices.

When a child becomes proficient at making choices, it's time to introduce more messages, or a communication "board." Look for next month's article for how to choose vocabulary for communication boards.

References are available upon request.

Carol Page O'Day is the staff speech-language pathologist with the SC Assistive Technology Program. She specializes in augmentative and alternative communication and literacy aids. She is available to help individuals with disabilities of all ages and their families and the professionals who serve them. To find out more information about the consultation services and device loan center, go to http://www.sc.edu/scatp/resourcecenter.htm.

A Parent's Perspective...
so we can learn

When I spoke to Kristy Leroux for this interview, she was changing her baby's diapers and looking after all three of her children. Even though she had her hands full, she made the time to share her and her daughter Katherine's experience in S.C.'s early intervention system. L.N.

Katherine began receiving early intervention in March 2008, when she was two years old. She was delayed in every thing other two year olds were doing— walking, talking, playing…, and began receiving services from an occupational therapist, physical therapist, speech-language therapist, and special instructor (called an "Early Interventionist" or "EI").

When services started, Kristy and the other team members also looked at what Katherine might need to learn to prepare for school, which would begin in a few months when she turned three. Because of her delays, the team planned for her to go to a special needs classroom at school.

So they all got to work. Kristy noted that, "The therapists and EI involved me in everything," and they all helped Katherine learn new skills— when the therapists and EI were there, and when they weren't. "Every day, Katherine was doing new and different things"— from learning to walk and talk to knowing her colors and shapes.

Now, a few months later, Katherine is almost three. Last week, they met with the school and had evaluations from school specialists— a preschool specialist and speech-language therapist— to determine the types of services that Katherine would need. The specialists determined that Katherine had made so much progress that she no longer needed special education services. She was too advanced for that and could now attend school like everyone else!

When asked what she would tell other parents who were just beginning services, Kristy said, "If I could recommend anything to other parents, it would be to say, 'Don't hesitate. If you think your child might have some needs, make contact and you will begin getting services if your child qualifies.'"

Kristy explained that it was hard to think about arranging for special services for Katherine. "I hesitated, and Katherine could have had so much more therapy and intervention." "It may have been pride in thinking there was nothing really **wrong** with Katherine, but I hesitated in making the contact."

Looking back now, Kristy says, "Katherine has made so much progress. It was a great experience and a good decision."

Thank you Kristy for sharing your story and thoughts.

BABYNET UPDATE From Dr. Debra McCoy, Provider Relations

BabyNet Mandatory Provider Trainings

The BabyNet Provider Relations Office has scheduled mandatory training for all contracted providers for the months of October, November and December 2008. It is mandatory that all contracted providers attend one of the scheduled sessions. If you are unable to attend one of these sessions, you must email Debra M. McCoy in BabyNet Central Office at mccoydm@dhec.sc.gov to let her know why you cannot attend one of the scheduled sessions and to coordinate an alternate training date. All contracted providers are required to receive this training by December 15, 2008. All new providers will receive this training after receipt of their contract, prior to providing BN services. Failure to complete the training by this date can result in a hold on BabyNet payments to affected providers until the training is completed. We are also asking that Service Coordinators and Early Interventionists attend this training as well.

Due to the high cost of gas and travel restrictions imposed by many agencies and entities, trainings have been scheduled in each System Point of Entry area, however, feel free to attend any of the scheduled meetings if you cannot attend the one in your area. Meetings are scheduled from either 9:00 a.m. to 3:00 pm or 9:30 a.m. to 3:30 p.m. depending on the location of the training. We ask that you reserve the date and time of the session most convenient for you and make plans to attend. The tentative agenda for the training consists of the following:

- Provider Orientation to the BN System (provider's role as related to the required components of the system)

- BabyNet changes in reimbursement rates

- Mandatory changes regarding face to face services and the required frequency and duration of those services

- Implementation of the consultative model

- New contract requirements for BN PTAs, OTAs and ST assistants

- Comprehensive System Of Personnel Development for Contracted Providers

The schedule of training sessions is on the next page. All providers must register for the training to ensure that we have adequate space. To register, email Robin Morris at morrisrh@dhec.sc.gov. If you have any questions about the training, feel free to contact Dr. Debra M. McCoy by email at mccoydm@dhec.sc.gov. Thanks in advance for your cooperation in this matter. We look forward to seeing you at the training.

BABYNET UPDATE From Provider Relations
Continued from page 14

BABYNET MANDATORY STATEWIDE PROVIDER TRAININGS

Region	SPOE Area	Training Date	Location	Time
V	Aiken	10/15/2008	Aiken County agricultural Bldg. Auditorium – Suite 500 1555 Richland Ave. E. Aiken, SC 29801	9:00-3:00
	Orangeburg	10/16/2008	Orangeburg County Health Department 1550 Carolina Avenue Orangeburg, SC 29115	9:00-3:00
VI	Conway	10/22/2008	TBA	9:00-3:00
VII	Charleston	10/28/2008	Charleston County Public Library 68 Calhoun Street Charleston, SC 29401	9:30-4:00
VIII	Colleton	10/29/08	Point south 634 Campground Road Yamassee, SC 29945	9:00-3:00
II	Spartanburg	11/5/2008	Spartanburg County Library 151 S. Church St. Spartanburg, SC 29302	9:30- 4:00
	Greenville	11/6/2008	Center for Developmental Services 29 N. Academy St. Greenville, SC 29601	9:00-3:00
III	Columbia	11/12/2008	Richland County Health Department Room 4070 2000 Hampton St. Columbia. SC 29204	9:00-3:00
	Rock Hill	11/13/2008	Lancaster County Health Department 1070 Heckle Blvd Rock Hill SC 29732	9:00-3:00
IV	Florence	12/2/2008	TBA	9:00-3:00
	Sumter	12/3/2008	TBA	9:00-3:00
I	Greenwood	Week of 12/8/2008- 12/11/2008 TBA	Burton Center 2605 Hwy 72/221 E. Greenwood, SC 29649	9:00-3:00
	Anderson	Week of 12/8/2008- 12/11/2008 TBA	Anderson County Health Department 220 McGee road Anderson, SC 29625	9:00-3:00

More News and Updates

TECS Update from Kristie Musick, Project Director

TECS will soon be announcing a series of conference calls for <u>BabyNet service providers</u> on the use of TECSBOOK, an online e-learning series designed to support providers in meeting the BabyNet contract requirements for the Comprehensive System of Personnel Development (see the online BabyNet Policy and Procedure Manual, Appendix 7, for additional information about these requirements at http://www.scdhec.net/health/mch/cshcn/programs/babynet/policy.htm).

Conference call dates and times will be announced through the TECSINFO Listserv. If you are a BabyNet service provider, and are not yet on this important Listserv, please go to http://uscm.med.sc.edu/tecs/subscribe.htm to join now!

Each newsletter will feature updates from state or national associations on current activities related to early intervention. A report about early intervention (EI) activities at the American Speech-Language-Hearing Association (ASHA) begins this topic, with information from more disciplines to follow in future newsletters.

ASHA Early Intervention Activities

ASHA Publishes Documents in Early Intervention for Speech-Language Pathologists

by Danielle Varnedoe, M.A., CCC-SLP, SCSHA VP Clinical/Professional Affairs, USC COMD Clinic Director

In January of this year, the American Speech-Language-Hearing Association published four (4) documents related to the roles and responsibilities of speech-language pathologists involved in early intervention. The primary goal of these official statements was to provide speech-language pathologists with information on best practices and efficacy of treatment for infants and toddlers with disabilities. The scope of topics included in these publications range from information on developmental and environmental risk factors, cultural and linguistic differences to consider, guiding principles underlying best practices, and core knowledge and skills necessary in early intervention speech-language pathology practice. These comprehensive guidelines stress the important role that appropriately trained speech-language pathologists have as members of the early intervention team. ASHA members may access this information on the ASHA website, at http://www.asha.org.

All early intervention team members can find helpful links and resources at:

Physical Therapy websites— http://www.apta.org//AM/Template.cfm?Section=Home, http://www.scapta.org/

Occupational Therapy websites— http://www.aota.org/, http://www.scota.net/

Speech-Language Pathology and Audiology websites— http://www.asha.org, http://www.scsha.com/

Mark your calendars!

Some Upcoming Workshops

October 10-11, Augusta, GA, A Whole Child Approach to Feeding: What do you do now? Contact and sponsors: Therapeutic Interventions of Georgia and USC Department of Communication Sciences and Disorders.

October 15, Charlotte, NC, Make and Take—Do and Learn: Optimizing Student Outcomes in Language and Literacy. Contact: 888-696-9655 or email info@nss-nrs.com

October 16-17, Columbia, SC, Beckman Oral Motor Assessment & Intervention Seminar. Contact: 407-590-4852 or visit www.beckmanoralmotor.com

November 14, Columbia, SC, South Carolina Deaf/Hard of Hearing Education Summit Conference, Literacy: What Works! Contact: Lisa Borden, Director of the South Carolina School for the Deaf and the Blind Hearing Outreach Program, at lborden@scsdb.org or 803-896-9711.

October 24, Columbia, SC, Coding and Billing for Therapy and Rehab. Sponsor and contact: Health Education Network, LLC, email—ssell@health-ed.com

Workshops sponsored by the SC Autism Society, visit http://www.scautism.org/2008workshops.html

Workshops sponsored by the SC Assistive Technology Program, visit http://www.sc.edu/scatp/trainingschedule08.html

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A Few Helpful Website Resources— information to share with families

- http://www.cdc.gov/ncbddd/autism/actearly/ for free downloadable factsheets, milestones, and more resources to share with parents and other caregivers

- http://www.firstsigns.org/ for information on early signs of autism, for families and providers

- http://www.pbs.org/parents/childdevelopmenttracker/ to access useful information and ideas for parents and other caregivers

TECS is contracted by the IDEA Part C lead agency (DHEC-BabyNet) to provide a comprehensive statewide system for personnel development and technical assistance.

BabyNet
South Carolina's Early Intervention System
SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

IDEAs that Work

If you need paper copies of the newsletter, have any questions about this newsletter, or would like to submit comments or suggestions, please email:
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