ONTARIO ASSOCIATION
for
INFANT DEVELOPMENT

MAINTAINING EXCELLENCE

BEST PRACTICES
for
INFANT DEVELOPMENT PROGRAMS,
SECOND EDITION (2006)

Manual and
Program Self Evaluation Tool

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ONTARIO ASSOCIATION
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INFANT DEVELOPMENT

MISSION STATEMENT

Recognizing that infancy and early childhood are crucial periods in the healthy development of an individual, the Ontario Association for Infant Development exists primarily to

- **develop, promote and support policies, services and research in the area of children birth to six in the Province of Ontario**

- **share information among professionals working in the area of infancy and children birth to six**

- **promote ongoing education for members and the community at large**

- **affiliate with other like-minded organizations**

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O.A.I.D. thanks the members of the original Best Practices Task Force who dedicated countless hours to what was a long-term process while maintaining their energy and enthusiasm for this project. For a list of the Task Force members, please see Appendix 1.

A key element of the original production of this document was feedback from of a group of professionals across Canada, known as "the think tank". These people reviewed drafts of surveys and documents throughout the process, providing valuable suggestions and considerable moral support. These individuals are listed in Appendix 1.

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Maintaining Excellence (the Second Edition of Best Practices, 2005) is the revision and expansion of the original document. It reflects new guidelines and changes in practice. The O.A.I.D. Best Practices Working Group members are

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INTRODUCTION

THE HISTORY OF THIS BEST PRACTICES DOCUMENT

Since its inception in 1980, the Ontario Association for Infant Development (O.A.I.D.) has had an ongoing commitment to support the highest quality interventions for infants, young children, and their families in Ontario. O.A.I.D. has conducted many activities related to this commitment. These Best Practices are one of the supports created.

In Ontario, Infant Development Programs, originally known as infant stimulation programs, first started in 1975. In 1977, the Ministry of Community and Social Services published "Infant Stimulation Guidelines" to provide some general direction for these fledgling services. (Ministry of Community & Social Services, 1977) The number of programs steadily increased under the sponsorship of the Ministry of Community and Social Services until the 1980's, by which time 45 programs had been established. Although no new programs have come into being since that time, there have been several changes. For example, many existing programs have expanded their services. Infant development programs find themselves constantly challenged to be flexible and to offer an increasingly wider range of supports in an increasingly complex society.

In 1987, the Ministry of Community and Social Services of the Ontario government published the "Infant Development Program Guidelines". (Ministry of Community & Social Services, 1987) This document was prepared to provide guidance "regarding the design, management, and delivery of infant development services". These Guidelines basically summarized the "state of the art" and provided considerable useful information for infant development programs.

By the early 1990's, however, it was obvious that there was a need for an updating of the 1987 Guidelines to be congruent with current service philosophy and government policy. Increasingly sophisticated research was being published which indicated new directions in early intervention. Therefore, O.A.I.D. committed itself to the establishment of Best Practices guidelines which reflected the systems and values of Ontario based Infant Development Programs and the families they served.

In 1994, the Ontario Association for Infant Development established and funded a Task Force to identify Best Practices for Infant Development Programs in Ontario. This Task Force was comprised of volunteers from Infant Development Programs throughout the province.

From August 1994 to June 1995, Task Force members reviewed and discussed an extensive literature on early intervention, eventually reaching consensus on a set of Best Practices principles.

Staff and families from infant development programs across Ontario were then surveyed to determine if they believed that the draft guiding principles were relevant. In 1996, the

Best Practices Guiding Principles were published by O.A.I.D. (See Appendix One) Throughout the process of identifying guiding principles, it was clear that, to be practically useful, the principles would need to be translated into concrete actions. With the publication of the Guiding Principles in 1996, O.A.I.D. began exploring funding options to support the next steps in this development.

In 1998, the Ministry of Community and Social Services funded O.A.I.D. to identify Best Practices for Infant Development Programs and publish a Best Practices Document, as well as to conduct training with Infant Development Programs in Ontario on how to use the Program Self Evaluation Tool.

In 1998, O.A.I.D. established a second Task Force representing programs throughout the province to guide the process of turning the philosophy of the Guiding Principles into actual practice. It developed "Indicators" which were descriptions of the specific activities that an infant development program should carry out to follow the Guiding Principles. The original eight Content Areas were maintained with a number of Indicators being created for each Content Area. Each Indicator was included only when consensus was reached among all Task Force members as to the relevance and importance of the Indicator.

Once again, the Task Force sought feedback from staff and families across Ontario. To ensure that the Indicators made sense to those who were directly involved in program delivery, an extensive survey was undertaken in October, 1998, using questionnaires to assess the applicability and importance of each individual Indicator.

In total, **213 staff surveys** from 87% of the infant development programs across Ontario were returned completed. The geographical distribution of staff survey respondents represented the entire province. With regards to program size, 46% of the responding programs served more than 125 clients annually, with the remainder serving less than 125 clients annually.

In addition, **241 parent/guardian surveys** were returned completed, representing 63% of infant development programs. 49% of these responding programs served more than 125 clients annually. Once again, the parent/guardian respondents represented programs that were geographically distributed across the province.

Specific criteria were used to rate the acceptability of the Indicators. A cut off of 75% agreement among the staff respondents or parent respondents was considered to be general support for a Indicator. Any Indicator that received less than 75% support was either changed or eliminated. For example, based on feedback, several Indicators were reworded to be more specific or applicable. Also, a few Indicators were moved to different Content Areas.

Clearly, because there was a significant response rate and diversity of respondents, the Task Force felt confident that the importance of the Indicators was validated. **The Task Force was gratified by the support and commitment demonstrated by the many**

staff and families who assisted with the survey process.
The last step in the process was the creation of the Best Practices Manual and the Program Self Evaluation Tool. However, O.A.I.D. had no doubt that the process was continuous and that it was indeed a work in progress. In 2001 the Ministry of Community and Social Services released the "Guidelines for Ontario's Enhanced/Expanded Infant Development." (Ministry of Community & Social Services, 2001) This resulted in the 2005 revision of the Best Practices Manual.

As we continue to gain knowledge and as families' needs change, we will most assuredly find ourselves building on this Best Practices document to produce more updated materials in the future.

DEFINING "BEST PRACTICES"

For many years, the term "best practices" has been utilized. There are literally thousands of best practices manuals that have been published, covering diverse topics such as human services, business, manufacturing, and science. The concept of best practices captures the idea that both people and organizations are doing what research/experience states is the optimum for their business. This would include performance that is both efficient and effective.

O.A.I.D. believes that working with infants and young children encompasses a variety of practices. Some practices are basic requirements for all infant development programs and are consistent over time. Always obtaining appropriate consents is an example. However, other practices will be modified over the years as our knowledge broadens, technology improves, and attitudes change. This type of evolution is perfectly reasonable. Furthermore, different infant development programs may utilize different practices according to individual factors such as geographical catchment area, availability of resources, percentage of clients with English as a second language, etc.

O.A.I.D. believes that it is critical to capture the dynamic and individualized nature of infant development programs. This Manual should be considered a work in progress. This is far from the last word in infant development practices, and changes will occur over time.

From O.A.I.D.'s perspective,"best practices" have several characteristics:

❶ Best practices are founded upon value statements. These can be expressed in many different ways, such as beliefs, ethics, or principles. It is these values which provide the focus for any best practices.

❷ Best practices state goals for performance, based upon these values. Best Practices suggest what activities a program can carry out to ensure that its services are being delivered with the utmost effectiveness, while maintaining the stated value base.

❸ Best practices are grounded in the most up to date research and knowledge that is available in the applicable field.

❹ Best practices define a standard, a level of excellence to which all can aspire.

In the case of O.A.I.D.'s Best Practices, the values are extensively reviewed in the Guiding Principles. The Best Practices Manual and the Program Self Evaluation Tool concentrate on the goals for performance.

The O.A.I.D. Best Practices are stated in goal format. As with all goals, Best Practices offer a direction for the future. We do not expect that programs can equally well meet these Best Practices. Best Practices are rated on a continuum, according to how frequently a program carries out the activities. Most programs will fall somewhere along this continuum, influenced by many factors such as funding, program policy, consumer input, and government regulations. While some of these factors can present barriers to achieving Best Practices, it is crucial that programs view these barriers as challenges to be overcome rather than permanent impediments. It is expected that programs will use the Program Self Evaluation Tool to creatively minimize or eliminate barriers.

We urge programs to recognize the importance of Best Practices with regards to providing the highest quality of services and to accept the challenge of working towards the achievement of all Best Practices.

EARLY INTERVENTION and THE FAMILY-CENTRED APPROACH

The family-centred approach is basic to all the Best Practices identified by O.A.I.D. It is the core value of this Manual, and will be reflected throughout all the Content Areas.

We wish to stress that being family-centred is essential to Best Practices. Of course, all contemporary human service staff endeavour to work in an empowering manner with service recipients because we believe that this is morally correct and ethically valid. However, it is not only a matter of values, it is also a matter of clinical efficacy. If we want our work with infants and young children to produce benefits that last over time, the family-centred approach is vital.

The early intervention process has long been recognized as effective in producing ***short term*** beneficial results for the infant or young child.

"Contemporary comprehensive early intervention programs for children at risk and for those with established disabilities reveal a consistent pattern of effectiveness as these programs are able to reduce the decline in intellectual development that occurs in the absence of intervention". (Guralnick, 1998)

However, long term benefits have not been realized from the more traditional focus:

"The outcomes described to this point are short-term, however, evident only during the

course of the program, soon after the program has ended, or later on, but still during the first five years of life". (Ibid)

It is only recently we have begun to understand that to produce ***long term*** benefits for the infant or young child requires that we develop a more holistic approach through which we support the child's family and build community.

This holistic approach includes

- ☆ working collaboratively with families
- ☆ dealing with the family's concerns which include, but are not limited to, the child's development
- ☆ teaching parents skills (Webster-Stratton, 1997)
- ☆ providing parents with a wide range of information on topics such as child development, what services are available in their community, how to advocate, and stress management techniques
- ☆ nurturing the development of positive parent-child interactions (Mahoney et al, 1998)
- ☆ supporting parents to relieve stressors in their lives which relate to both the child and other factors such as lack of education, marital dissension, unemployment, or poverty (Guralnick, 1998)
- ☆ connecting parents to the community
- ☆ building a community that is more supportive and receptive to both children and families (Sviridoff & Ryan, 1997)

Infant Development Programs are a key component of the holistic approach, and thus should develop services that have this broader holistic perspective. O.A.I.D. Best Practices emphasize that:

building the strengths of the family results in healthier children, families, and communities.

LEGAL CONSIDERATIONS

O.A.I.D. recognizes a number of legislative and regulatory requirements which govern the conduct of all health care and social service providers. Legislation which may impact on infant development programs includes (but is not limited to) the Registered Health Professionals Act, Freedom of Information and Protection of Privacy Act, Child and Family Services Act (including child welfare/protection), Ontario Hospitals Act, and Health Care Consent Act.

This Manual and Self Evaluation Tool identifies many of these legislative requirements as indicators of Best Practice.

It is incumbent upon infant development programs to be knowledgeable about all relevant legislation and the requirements imposed on staff.

SECTION 1

THE BEST PRACTICES MANUAL

SECTION 1
THE FORMAT OF THE BEST PRACTICES MANUAL

THE FORMAT OF THIS BEST PRACTICES DOCUMENT

This Best Practices document is divided into three Sections:

Section One begins with an overview of the Best Practices Manual. After that, there are four Parts that describe the evaluation and planning processes. Part One is a General Introduction which includes General Instructions for using the Tool. This is followed by Part Two, an Overview of the Program Self Evaluation process and then Part Three, an Overview of the Planning for Change process. Both of these are practical "hands on" processes which programs can use to evaluate their success in achieving Best Practices. In Part Four there is a statement regarding O.A.I.D.'s perspective on both of these processes which are viewed by O.A.I.D. as ongoing and evolving.

Section Two is the actual manual. It consists of nine Parts. Parts One through Eight discuss each of the eight Content Areas. Each Content Area begins with a theoretical focus, discussing value base, research results, and goals, called Indicators, for each of the eight established Content Areas. Each Content Area concludes with the planning and evaluation forms for that Area. The Section concludes with Part Nine, a Bibliography.

The document ends with Section Three, the Appendices. This consists of the O.A.I.D. Best Practices Guiding Principles on which this entire document is based.

This document is both theoretical and practical. Readers will find that the Manual is highly informative, including research and background materials. The Tool provides a ready made system to use which logically links the results of the Best Practices Program Self Evaluation to the process of planning.

We hope that you find this Best Practices document to be useful and thought provoking. It certainly represents thousands of hours of commitment from volunteers across Ontario who, like you, believe in the importance of providing the best possible quality of infant development services.

In all sections, the term family also refers to all of the child's caregivers.

SECTION 1
PART 1: GENERAL INTRODUCTION

THE FORMAT OF THIS SECTION

This Section is divided into two Parts.

The first Part describes the Program Self Evaluation process, while the second Part describes the Planning for Change process. The information from the Program Self Evaluation is utilized to conduct planning for your Infant Development Program.

THE PROGRAM SELF EVALUATION TOOL AS AN OPPORTUNITY FOR CHANGE

Some programs look upon a Best Practices Program Self Evaluation process with trepidation or a sense of futility. Questions are asked – "Are we expected to be perfect?'; "How can we improve with limited resources?"; "Will our funding be reduced if we don't measure up?"

However, Program Self Evaluation can also be seen in a positive light. A program can rejoice in its strengths and recognize its limitations. These limitations offer a direction for future improvement.

There are several points we wish to emphasize about the O.A.I.D. Best Practices Program Self Evaluation Tool:

- there is no infant development program in Ontario that will be perfect!
- only your program will know the results of your Program Self Evaluation so you need not fear that the results can be used by others to your detriment
- regional differences are acknowledged – use the process as it makes sense in your own community
- a particular rating may be viewed as accomplishment for one program but insufficient for another program. The achievement of a particular Best Practice will depend on individual circumstances such as how long a program has been in existence, the number of staff, the diversity of the community's population, the geographical size of its catchment area, etc.
- while all programs face valid barriers, these barriers should not be used as excuses to stop a program from working to improve
- Program Self Evaluation is intended to be a self comparison process so that each program can track its own progress over time, rather than worrying about how it compares to other programs

Therefore, Program Self Evaluation is an opportunity for positive change. It offers programs the most up to date knowledge in Best Practices and a format to utilize in order to achieve Best Practices.

GENERAL INSTRUCTIONS ON USING THE PROGRAM SELF EVALUATION TOOL

This Program Self Evaluation Tool has been designed for practical use by service deliverers. It has been developed as a Workbook which contains a section for each Content Area which includes all of the forms required to complete both the Program Self Evaluation and the Planning for Change processes for that Content Area.

The process is carried out in the following way:

1. Conduct the Program Self Evaluation Process for each Content Area.
2. Utilize the information from the Program Self Evaluation results to complete the Planning for Change Process for each Content Area.
3. Complete one Content Area before moving on to the next to maximize the effectiveness of this Tool.
4. If possible, plan on an annual basis. The planning forms can be photocopied for reuse every time you undertake a planning process. Program Self Evaluation usually occurs approximately every three years, at which point a program can investigate how much progress has been made over the preceding three year period, as well as planning for the future. The Program Self Evaluation forms can also be photocopied and reused.

It is highly recommended that all staff in your program complete a separate evaluation of the program. This provides a wide range of input and information from all sectors of your service delivery system. Bringing all staff together to discuss the ratings and then coming to agreement on one unified result is an excellent opportunity to maximize everyone's participation in planning for your program's future.

SECTION 1
PART 2: AN OVERVIEW OF THE PROGRAM SELF EVALUATION PROCESS

HOW TO CARRY OUT THE PROGRAM SELF EVALUATION PROCESS

The Program Self Evaluation Process consists of 4 steps. Every step should be completed for ***each*** Indicator in ***all*** the Content Areas.

Step 1: Rate How Frequently The Indicator Takes Place In Your Program

Each Indicator should be rated on the Program Self Evaluation Chart according to how frequently it occurs in your program. The rating choices can be compared approximately to the percentage of time the Indicator happens in your program as follows: Never (0%), Rarely (25%), Sometimes (50%), Usually (75%), and Always (100%). These percentages are rough guidelines. It is not likely that you are keeping statistics regarding all the Indicators, so in some cases you may have to take your best educated guess as to frequency.

Step 2: Decide if You Need to Improve In Each Indicator

Depending on the nature of the Indicator and your rating, you can choose either Yes (you need to improve regarding this Indicator) or No (you do not need to improve). Remember that the frequency rating alone is not the deciding factor. Rather, the nature of the particular Indicator determines your decision.

For example, an Indicator such as "Consent is obtained for all gathering and sharing of information" should occur "Always" and if it doesn't, improvement ***must*** be a goal. However, other Indicators, such as "The program enables families to have input into strategic planning and program development processes" might be rated as 50% of the time and that rating could be realistic for this type of activity. Therefore, you could answer No to the "Need to Improve" question. This decision should not be based on the fact that there are barriers to improvement but rather should be based on what should be occurring in your program.

As a general rule, all Indicators should be occurring to at least a minimal extent in all programs. ***Therefore, any Indicator rated with Never needs improvement.***

Similarly, practically all of the Indicators should be occurring with some regularity. ***Most Indicators rated with Rarely also need improvement.***

At this point in the process you now will have a list of Indicators which your program has

targeted for changes.

Step 3: Decide When You Will Work On Each Indicator That Needs Improvement

You may find that there are several areas in which you would like to improve your program. It is not realistic to try to tackle all these Indicators at once. Therefore, the next step is to decide when you will work on each of the Indicators. There are two choices with regards to this time frame.

You can place a Indicator in the "Immediately" category, in which case you will start the improvement process right away (this will involve completing the Planning for Change form for this Indicator in the very near future).

The other choice is to place the Indicator in the "Next 3 Years" category. It is essential to remember these Indicators later! Indicators for which this option is chosen should be reviewed at least annually. At some point in the next 3 years these Indicators should be activated and improvement should be undertaken.

Step 4: Record All Indicators In The Content Area To Be Worked On Immediately

Record all the Indicators that have been designated for Immediate improvement on the "Indicators Which Have Been Rated for Immediate Improvement" form. This will provide a summary of what you will be working on in this Content Area right away.

When you see this list, you may discover that you have too many Indicators to deal with immediately. In this case, you may decide to move some Indicators into the "Next 3 Years" category.

On the other hand, you may discover that you have the resources to work on more Indicators right away. Therefore, some Indicators can be transferred into "Immediately" from the "Next 3 Years" rating.

Step 5: Tracking Indicators Requiring Future Work

Using the form entitled "Indicators Requiring Future Work", transfer the Indicators from each Content Area that have been Rated for work within the "Next 3 Years". Revisit that form on a regular basis to ensure that these Indicators are not overlooked in future planning.

Step 6: Move Into The Planning For Change Phase

The list of Indicators for immediate improvement is now utilized in the Planning for Change.

SECTION 1
PART 3: OVERVIEW OF PLANNING FOR CHANGE PROCESS

HOW TO CARRY OUT THE PLANNING FOR CHANGE PROCESS

The Planning for Change Process consists of 7 steps. Every step should be completed for ***each*** Indicator in ***all*** the Content Areas that has been rated "Immediately" for improvement.

Use ***one*** Planning for Change form for ***each*** Indicator and complete the entire form for that Indicator before moving on to the next Indicator.

Step 1: Develop a Goal for the Indicator

Once you have determined that you need to improve in a specific Indicator and that you want to work on that Indicator "Immediately", the first step in the planning process is to develop a goal for that Indicator. This entails deciding what changes you would like to see and translating those ideas into a goal. This is very similar to the goal setting process used with developmental programs for the infants and young children you support.

It is essential to remember that a goal must describe observable and measurable change.

This ensures that everyone understands the meaning of the goal in the same way and that progress can be specifically evaluated.

For example, within the Content Area of Community Building, your Program may have chosen the Indicator "The Program participates in community education and advocacy" for immediate improvement. In completing the Program Self Evaluation, you discovered that only about 3% of staff time has been spent on this type of activity over the past years and rated this Indicator at "Rarely". If you decide that your ideal rating would be "Sometimes" for this Content Area, then you can translate that concept into a measurable goal. The goal could state, for example, that 10% of staff time will be spent in community education and advocacy. Progress towards this goal could be easily measured at a later date.

It is also important to remember that the amount of improvement desired will differ from Program to Program. Design a goal that is reasonable and appropriate for your Program. The basic purpose of the Program Self Evaluation is to make positive changes and to do so at a pace that makes sense for your circumstances. You will be comparing your Program only to itself.

Step 2: Decide on a Time Frame for the Goal

Once you have developed a goal for the Indicator, decide what the target date is for accomplishing that goal. Typically, goals take at least 1 year to accomplish. However, a goal that requires less change could take less time.

Once again, it is important to be realistic in choosing a time frame, keeping in mind the amount of resources that are available in your Program to work on the goal.

Step 3: Identify All Barriers

Having specified a goal and a time frame, the next stage is to identify any barriers that might impede accomplishment of this goal.

A barrier can be any number of factors – lack of staff time, a large geographical area, a significant number of referrals from child welfare agencies, a diverse clientele, internal politics at your agency, the political climate of your community, etc. Undoubtedly some barriers exist that are extremely difficult to change. This does not mean that progress on an Indicator is not possible. Many of the Best Practices Indicators are not dependent on changing such barriers. Instead they require changes in values or in processes.

Not all goals have barriers. In some cases, your Program might not have worked on a particular Indicator simply because you had not identified it as a Best Practice.

It is crucial to be honest about barrier identification. List all the barriers, even if the list seems long or beyond your control. Ignoring a potential barrier will undoubtedly backfire since the issue is bound to arise when you are trying to work on your goal.

Many times, people become disheartened when they think about a particular barrier and do not believe that anything can be done about that barrier. This can happen, for example, when considering the lack of resources a Program has. A common question is “What can we do without more funding?”

Undoubtedly, this is a serious issue. However, it is not advisable to accept that as an excuse and to thus give up working on the goal. It is certainly a fact of life that funding can’t keep up with service demands. However, there may be many different ways to approach an issue, and more funding is not always the answer. As a matter of fact, many of the Best Practices Indicators are not dependent on funding.

Interestingly enough, after planning for several Indicators you may find that similar barriers are mentioned many times. Therefore, dealing with one barrier may help with the accomplishment of several goals.

Step 4: Identify Strategies to Deal with the Barriers

The most challenging part of the planning process can be the identification of strategies to deal with the barriers!

It is helpful to approach this part of the planning as a brainstorming exercise. Planning participants should be encouraged to offer any and all ideas. Frequently, it is the spontaneous suggestion that is the most creative and, ultimately, successful. Fortunately, strategies do not have to be perfect! Programs are encouraged to try out different approaches to dealing with barriers and to see what works.

Step 5: Break the Strategies Down into Tasks

Once the strategies have been decided upon, the next step is to break them down into smaller steps. We are calling these smaller steps "tasks", although you may be familiar with the terms actions or activities that are used in other planning formats.

Developing tasks for your Program is again very similar to developing tasks in developmental programs for individual infant and young children. Basically, the larger job is divided into more manageable, short term activities. Tasks usually take up to 6 months to accomplish, although many are much shorter term.

Each task will include three components:

- The actions to be undertaken.
- Who is responsible for the actions.
- A target date for accomplishing the task.

More than one person can share a task and, in some cases, people besides staff may be involved.

Step 6: Evaluation

At regular intervals, planning participants should revisit the Planning for Change form for every Indicator. If a task has been completed, the date of completion is noted on the form.

If the task has not been completed by the target date, the Comments column can be used to indicate what will be happening with that task. For example, the target date could be extended, the task could be abandoned, a different person may be assigned to the task, etc.

Step 7: Revisit the "Indicators Requiring Future Work" Form Annually

It is important to also remember those Indicators that have been designated by your Program for improvement in the "Next 3 Years". In every Content Area, those Indicators listed on the form entitled "Indicators Requiring Future Work", should be revisited at each annual planning, to ensure that no Indicator is forgotten.

SECTION 1
PART 4: PROGRAM SELF EVALUATION AND PLANNING AS AN ONGOING PROCESS

Best Practices are the ideal. Each program will work towards this ideal at its own pace. The processes of Program Self Evaluation and Planning for Change are ongoing.

Programs are encouraged to ***frequently*** investigate what progress is being made with regards to tasks and to formally plan ***annually***.

Of course, Best Practices in Infant Development will change over time as the needs of the clients change and the sophistication of our knowledge base expands. Therefore, the Program Self Evaluation and Planning for Change processes remain a constant and exciting challenge.

SECTION 2
CONTENT AREA 1 – FAMILY-CENTRED SERVICE

PHILOSOPHY AND VALUES

"Family-centred care is a philosophy of care in which the pivotal role of the family is recognized and respected in the lives of children with special needs. In this philosophy families should be supported in their natural care-giving and decision-making roles by building upon their unique strengths as people and families". (Brewer et al, 1989)

Family-centred service is made up of a set of values, attitudes and approaches to services for children with special needs and their families. Family-centred service recognizes that each family is unique; the family is the constant in the child's life; and family members are the experts on the child's abilities and needs. (Centre for Childhood Disability Research, 2006)

The opening quotation provides an excellent starting point for an understanding of family-centred service as a belief in the rights and strengths of families. Family-centred Service refers to a particular approach to intervention that aims to support and strengthen parents' abilities to nurture and enhance child well-being and development. (Dunst, 1997)

Building upon these concepts, the two major premises that guide the O.A.I.D. philosophy of Family-centred Service are

- the FAMILY is the major decision maker in the child's life
- the PROCESS used in the service planning is essential to a satisfactory outcome

From these two statements, we have developed the value that is the foundation for this Content Area:

O.A.I.D. believes that parents have the right to make informed decisions regarding services including the establishment of goals and priorities, and the level and nature of their involvement in services.

Trivette and Dunst have conceptualized family-centred service as three separate but interrelated factors. (Trivette & Dunst, 1999) The first factor is *Participatory Helpgiving*, which focuses on behaviours that strengthen existing capabilities of the service recipient and promote new competencies in the service recipient. The second factor is *Relational Practices* which are comprised of good clinical skills such as compassion and active listening **plus** attitudes which clearly indicate belief in the capabilities of the service

recipient. The third factor is *Technical Quality* that consists of the professional utilizing knowledge and skills to competently perform his/her job.

From this, we can conclude that family-centred service includes the traditional clinical and technical skills, but these are not sufficient. Family-centred service also requires that staff work with families in a way that ensures that families are in control and that families utilize and expand their competencies.

There are several key reasons why family-centred service is so strongly promoted by O.A.I.D.:

- ✪ Families are central to children's well being. The pivotal role of the family in providing for the survival and nurturing of infants and young children should be recognized. The family is also the constant in the child's life, while service systems and personnel within those systems fluctuate.

- ✪ Families are diverse. Diversity in culture, race, socio-economic status and sexual orientation among families requires acceptance and respect.

- ✪ Families and children are unique. Each family has its own structure, roles, values, beliefs, and coping style. This requires an individualized and flexible approach to goal identification and service planning.

- ✪ Families have the right to make informed decisions regarding services, including the establishment of goals and priorities and the level and nature of their involvement in services. The primary aim of good service planning is to enable and empower families. To achieve this, all possible information and dialogue must be directed towards enhancing a family's management skills and promoting a sense of competence and worth.

- ✪ Families should be informed. Parents should receive, on an ongoing basis, in a respectful and supportive manner, unbiased and complete information about their child's care and development. Families should be actively involved in information gathering, assessment processes, and goal planning.

- ✪ Families should have well-coordinated service delivery in order to meet their needs. The usual demands and stresses of family life intensify when a family has a child with special needs. Collaboration occurs when the family is the final decision-maker, and the team (including the family), implements those decisions. Families should be supported if their choice is to take on the role of service coordinator.

- ✪ Families need normalization. Each child has the right to experience life in as normal a fashion and environment as possible. Service planning should reflect the most natural way for a child and family to operate privately and within their community. This includes the concept of integration within professional support

systems, and also includes supporting families in the maintenance and development of their natural support systems (e.g., extended family, neighbourhood support groups).

- ✪ Access to early intervention services should not be limited to referrals from professionals in the community (i.e. self referrals are acceptable).

O.A.I.D. Best Practices offer specific ways that infant development services can be provided in a family-centred manner. Service Coordination is an important part of family-centred service. Content Area 5 provides related indicators.

RESEARCH

An ever-growing body of research supports the family-centred approach to service delivery in early intervention programs. (Program and Professional Advisory Committee, 1995) This research investigates outcomes with respect to the infant or young child, the parents, and the family unit.

"Research and clinical practice have increasingly indicated that <u>how</u> help is provided is as important as <u>what</u> is provided if help-giving is to have positive consequences". (Trivette & Dunst, 1999)

This powerful statement by Trivette and Dunst is based upon over 20 years of practice, research and exhaustive literature reviews. Their findings, supported by those of many others, indicate the benefits of the family-centred approach. (Dunst, 1994)

It is crucial to ensure that intervention looks beyond the needs of the child and considers the family as a whole. Dunst concludes that "efforts directed solely or primarily at influencing child change do not deliver on their promise; and in those studies where positive effects are reported, the magnitude of observed influences is modest at best". (Ibid) A broader perspective is essential so that the family as both a unit, and as individual members, is considered.

Services should be tailored to meet the needs of the family as identified by the family. Guralnick refers to this as "family orchestrated activities", a particularly evocative phrase. (Guralnick, 1998) Not only is this essential to successful service delivery, research indicates that, unless early intervention services are responsive to the family's needs, these services can actually be ***counterproductive***. (Afflect et al, 1989)

Bailey et al specifically acknowledge the link between family outcomes and infant outcomes. (Bailey et al, 1998) In fact, they view the family-centred approach as so important, that they recommend that this approach should permeate all aspects of service delivery, including training, evaluation, planning, and service delivery.

Research indicates that the following outcomes are positively related to the family-centred approach: child competence and performance, parents' knowledge/skills with

which to mobilize their child's development, parents' well-being, parents' participation in home programming, family quality of life, community participation, family coherence, and overall life satisfaction. (Dunst, 1994; Dunst, 1997) It is interesting to note that family-centred service delivery does result in accomplishing the traditional early intervention goals related to the child's functioning **plus** improving family life in many other ways.

As well, family satisfaction with service delivery is higher when a family-centred approach is used. (Dunst, 1997) We should understand that satisfaction is a significant indicator, since it reflects the program's ability to engage families and meet their needs.

Research indicates that Family-centred Service approaches result in

- ✪ a higher rate of achieving goals for the infant or young child and the family
- ✪ an increased level of family satisfaction with the program
- ✪ a positive impact on family functioning in general

BEST PRACTICE INDICATORS

There are several specific activities or processes that an infant development program should conduct if it is to provide services in a family-centred way. The following Indicators describe these Best Practices.

1. Written program material clearly states a family-centred focus.

1. An Individualized Family Service Plan (IFSP) is developed for each family. Goals and plans are developed collaboratively and consider a family's choices, needs, priorities, and resources. IFSPs are reviewed regularly.
2. Meeting times, frequency, and locations are determined by family needs and choices.
3. Families determine who will participate in intervention (e.g. relatives, caregivers, friends).
4. Fathers and mothers are routinely provided the opportunity to participate.
5. The needs of the siblings are considered when developing a service plan (e.g. included in activities, sibling groups, and information on community resources for siblings).
6. Suggested activities are designed to be incorporated into daily routines, family life, and parent-child interactions.
7. Family participation in infant development programs is voluntary.
8. Services are explained to families, including the benefits and potential risks of

these services.

9. Once families agree to participate in these services after this explanation, their agreement is documented in writing in the client record.
10. Families receive information in a variety of ways about community services and supports (e.g. community and educational opportunities, health resources, and other service providers).
11. The program supports families in making use of natural community supports and resources (e.g. religious, cultural, recreational, and familial supports).
12. Staff assist families to access and understand professional and technical information.
13. When English is not the first language, attempts are made to communicate in the language of family choice (e.g. use of interpreters, translation of written materials, and simplification of materials).
14. A continuum of services is provided based on the needs of the family, which may include home visits, drop-ins, consultation, workshops, groups or information materials.
15. Efforts are made to consider barriers such as travel costs and child care for families who receive services out of their home.
16. Families are informed of all record keeping.
17. The program provides opportunities for family-to-family connections (e.g. support groups, parent to parent linkages, parent newsletters, and sibling/grandparent groups).

CONTENT AREA ONE: FAMILY-CENTRED SERVICE

Two major premises from the O.A.I.D. Guiding Principles underlie the philosophy of Family-centred Service:

❶ the family is the major decision maker in the infant or young child's life
❷ the process used in the service planning is essential to a satisfactory outcome

Please rate your program on each Indicator listed in the following Program Self Evaluation Chart.

FAMILY-CENTRED SERVICE	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. Written Program material clearly states a family-centred focus.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
2. An individualized Family Service Plan (IFSP) is developed for each family. Goals and plans are developed collaboratively and consider a family's choices, needs, priorities, and resources. IFSPs are reviewed regularly.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
3. Meeting times, frequency, and locations are determined by family needs and choices.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
4. Families determine who will participate in intervention (e.g. relatives, caregivers, friends).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
5. Fathers and mothers are routinely provided the opportunity to participate.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

FAMILY-CENTRED SERVICE	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
6. The needs of the siblings are considered when developing a service plan (e.g. included in activities, sibling groups, and information on community resources for siblings).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
7. Suggested activities are designed to be incorporated into daily routines, family life, and parent-child interactions.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
8. Family participation in infant development programs is voluntary.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
9. Services are explained to families, including the benefits and potential risks of these services.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
l0. Once families agree to participate in services after this explanation, and their agreement is documented in writing in the client record.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
11. Families receive information in a variety of ways about community services and supports (e.g. community and educational opportunities, health resources, and other service providers).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

FAMILY-CENTRED SERVICE	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
12. The Program supports families in making use of natural community supports and resources (e.g. religious, cultural, recreational, and familial supports).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
13. Staff assist families to understand professional and technical information.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
14. When English is not the first language, attempts are made to communicate in the language of family choice (e.g. use of interpreters, translation of written materials, and simplification of materials).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
15. A continuum of services is provided based on the needs of the family, which may include home visits, drop-ins, consultation, workshops, groups or information materials.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
16. Efforts are made to consider barriers such as travel costs and child care for families who receive services out of their home.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
17. Families are informed of all record keeping.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

FAMILY-CENTRED SERVICE	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
18. The Program provides opportunities for family to family connections (e.g. support groups, parent to parent linkages, parent newsletters, and sibling/grandparent groups).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 26 to record all Indicators rated with ”Immediately” and to Page 28 to record all Indicators rated with “Next 3 Years”.

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record all the Indicators which you have decided need immediate improvement in the Family-centred Service Content Area.

1.

2.

3.

4.

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Please note: if you decide that there are too many Indicators in this Content Area for immediate work, you could choose to move some of the Indicators to the "Next 3 Years" rating. In that case, make sure to change the Rating on the Program Self Evaluation Chart which precedes this Page. **Please turn to the next page to complete a Planning Form for each Indicator remaining on your list for immediate improvement.**

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2
CONTENT AREA 2 – ACCESSIBILITY

PHILOSOPHY AND VALUES

Accessibility is defined as the quality of being easily approached or entered. (The American Heritage Dictionary, 1992) With regards to the provision of infant development programs, O.A.I.D. has a two-part definition of accessibility:

❶ the program should provide access to services regardless of individual or programmatic factors such as client risk status, client geographic location, or program size

❷ the program should ensure that the nature of its services and its intake process are widely publicized throughout the community so that all potential clients are made aware of the program as soon as their needs are identified

This is a broad based view of Accessibility, which links to the Content Area of Community Building since both recognize the necessity of community inclusion for both the infant or young child and his/her family.

The value that is the foundation for this Content Area is

O.A.I.D. believes that all families and children should have the opportunity to receive the services they need.

Essential elements of Accessibility are

✪ the infant development program is accessible to all families

✪ there is informed parental choice with regards to participation in any human service

✪ a reciprocal flow of information exists in which the community is aware of the presence and purpose of the infant development program ***and*** staff of the infant development program are informed about all the other resources that the community has to offer

✪ infant development staff promote the inclusion of the family and infant or young child in other community services

Staff training and service coordination are required to ensure the essential elements of accessibility are met.

RESEARCH

Research results regarding accessibility reinforce the importance of the earliest possible intervention and immediate service delivery.

The most significant document in many years regarding the need for early intervention has been published by The Canadian Centre for Advanced Research. (McCain & Mustard, 1999) Entitled "Reversing the Real Brain Drain: the Early Years", this report reviews a considerable amount of information from many disciplines such as neurology, developmental psychology, and pediatrics, to reach the conclusion that

"It is clear that the early years from conception to age six have the most important influence of any time in the life cycle on brain development and subsequent learning, behaviour, and health. The effects of early experience, ***particularly during the first three years***, on the wiring and sculpting of the brain's billions of neurons, last a lifetime". (Emphasis added)

This is an unequivocal statement of the inter relationship between the brain as an organ of the human body, and the infant's/ young child's development across all areas of her/his life including skills and behaviours.

In essence, The Early Years tells us that early intervention is crucial since there is a limited window of opportunity for the brain development that a human being requires for future success. There are physiological reasons why early intervention is irreplaceable. A child, who does not experience the required brain development as an infant/toddler, can never gain back what is lost. Supports and services at a later age can certainly help, but they cannot make up for the lack of physical brain development during these critical years. Thus early intervention programs are crucial and "the earlier in a child's life these programs begin, the better".

Furthermore, this report recognizes the importance of supports that relate not only to the child's needs, but also to the parents' issues on a broader level, including poverty and isolation.

In order to ensure that the infant or young child receives infant development services as soon as a need is identified, the infant development program must be

- well known and understood throughout the community, so that parents and professionals alike will recognize that the service is what the family requires and will make the early referral

- available in all communities so that families can get services quickly and feel accepted and supported when they make contact

Research results indicate that Accessibility is crucial because

- ✪ brain development between infancy and 6 years acts as the foundation for the later development of adult skills and behaviours
- ✪ the first 3 years of life is a crucial period in brain development for all children, especially those with biological and environmental challenges

BEST PRACTICE INDICATORS

There are several Indicators that relate to Accessibility:

1. The Program ensures that the community is aware of infant development services (e.g. pamphlets and community education activities) and the importance of early referral.
2. The Intake process promotes easy and early access to services (e.g. links with public health, hospitals, birthing centres).
3. Family referrals are encouraged, although referrals are accepted from any source with family consent.
4. Families eligible for services have equal access to services regardless of geographic location, program size or reason for referral.
5. Program staff, materials, and location should be reflective of the diversity of families across cultural, language, literacy, disability, and economic circumstances.
6. Staff are aware of current community resources available to families and collaborate to enhance accessibility for families.
7. Supports will be provided to families when there is a waiting list for a particular kind of service/intervention (e.g., home visiting). These may include phone contacts, drop ins, consultations, information materials, referral to other services, and contact with other parents.
8. The program collaborates with relevant community agencies that screen and track child development in that community.

CONTENT AREA TWO: ACCESSIBILITY

Accessibility involves a focus on inclusion of the infant and young child into the family system and inclusion of the family into the community (O.A.I.D. Guiding Principle).

Please rate your program on each Indicator listed in the following Program Self Evaluation Chart.

ACCESSIBILITY	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. The Program ensures that the community is aware of infant development programs (e.g. pamphlets and community education activities) and the importance of early referral.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
2. The Intake process promotes easy and early access to services (e.g. links with public health, hospitals, birthing centres).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
3. Family referrals are encouraged, although referrals are accepted from any source with family consent.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
4. Families eligible for services have equal access to services regardless of geographic location, program size, or reason for referral.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

ACCESSIBILITY	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
5. Program staff, materials, and location should be reflective of the diversity of families across cultural, language, literacy, disability, and economic circumstances.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
6. Staff are aware of current community resources available to families and collaborate to enhance accessibility for families.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
7. Supports will be provided to families when there is a waiting list for a particular kind of service/intervention (e.g., home visiting). These may include phone contacts, drop ins, consultations, information materials, referral to other services, and contact with other parents.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
8. The program collaborates with relevant community agencies that screen and track child development in that community.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 34 to record all Indicators rated with ”Immediately” and to Page 36 to record all Indicators rated with “Next 3 Years”.

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record all the Indicators which you have decided need immediate improvement in the Accessibility Content Area.

1.

2.

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Please note: if you decide that there are too many Indicators in this Content Area for immediate work, you could choose to move some of the Indicators to the "Next 3 Years" rating. In that case, make sure to change the Rating on the Program Self Evaluation Chart which precedes this Page. **Please turn to the next page to complete a Planning Form for each Indicator remaining on your list for immediate improvement.**

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2
CONTENT AREA 3 – HUMAN RESOURCES

PHILOSOPHY AND VALUES

The quality of an Infant Development Program will depend to a significant degree on the quality of the staff who provide its services. (Bruder, 1993) The O.A.I.D. Human Resources Best Practices have been developed to assist infant development programs to achieve and maintain this quality. Underlying this commitment to quality Human Resource practices is the premise that services should be shaped by the needs of those they serve rather than by the precepts, demands, and boundaries set by professionals.

Thus, providing services to infants, young children and their families requires that all staff and volunteers (where utilized) have competence regarding necessary skills ***and*** attitudes that support a family-centred approach.

The value underlying the Human Resources Content Area is:

O.A.I.D. believes that all families and infants/young children should receive the services they choose from staff who possess the highest level of competence and who are supported by their organization to achieve the highest possible level of performance.

This statement indicates that the infant development program has a considerable degree of responsibility for the hiring and retention of quality personnel. Therefore Best Practices in Human Resources focuses on the management of the organization rather than the actions of individual staff members. Points for the organization to incorporate into its Human Resources management are

- ✪ The staff complement includes a cross-section of professionals with backgrounds such as psychology, special education, nursing, physical or occupational therapy, speech and language pathology, social work or other forms of counseling, or other backgrounds including child development, early childhood education, and family intervention

- ✪ All staff are competent in their abilities to relate to families, to intervene and to collaborate

- ✪ Ongoing training focuses on the development of technical skills and personal and interpersonal skills, as well as an understanding of the philosophical approach

- ✪ All staff should have access to reflective supervision

- ✪ All staff should have access to consultation and collaboration with members of a team, and other professionals in the system of services in order to meet the wide variety of needs presented by infants/young children and families

- ✪ Organizational policies and processes should be fair and clearly defined, and available to all staff, volunteers, and students

RESEARCH

Considerable research has been conducted to investigate staffing quality in infant development programs. The conclusions are consistent across a variety of studies.

Research has been conducted to define the competencies of staff required for optimal outcomes. (The IMP Task Force, 2004) These include competencies under the following categories:

- the child
- influences on child development
- intervention
- ability to relate to families
- ability to intervene
- ability to collaborate
- skills in assessment and formulation
- personal and interpersonal skills

Training is a major factor that is highlighted by research. (Berlin et al, 1998; Raver & Kilgo, 1991; The TASK Project, 1990) It is clear that providing services to infants or young children and their families is a specialized profession and that staff must receive the appropriate training to understand the particular needs of this client group. This training should occur on a pre-service basis (i.e. before staff actually begin their job duties) and continually thereafter. Furthermore, appropriate training includes not only technical skills, but also the value base of inclusion and supporting family rights. (DEC Task Force on Recommended Practices, 1993)

Reflective supervision has proven to be a successful and useful method of supporting staff in human services programs. (Administration for Children & Families, 2002; Centre for Program Excellence, 2002). It has four components:

- it is available regularly

- it is collaborative and supportive
- it has a sound theoretical basis
- it is reflective

Research shows that reflective supervision can help overcome some of the symptoms of vicarious trauma that may result from this work and avoid burnout.

Research regarding Human Resources indicates that

- ✪ Infant development staff require competencies in working with families
- ✪ Infant development staff require a consistent and ongoing system of up to date and appropriate staff development
- ✪ Infant development staff require reflective supervision

BEST PRACTICE INDICATORS

Best Practices in Human Resources cover a variety of topics that relate to staff and volunteer performance, as stated below. Please note that the word staff as used in the following Indicators refers to all staff, including management.

1. The program has hiring policies that state minimum staff qualifications.
2. The program employs staff from a variety of educational backgrounds, training, and expertise.
3. Staff members are included in the hiring process.
4. The program has written job descriptions that articulate the requirement to work collaboratively with families and define the roles and responsibilities of staff.
5. Staff reflect a cross section of the community served by the program.
6. The program provides for systematic orientation and pre-service training of new staff.
7. The program provides for systematic orientation of contract workers, consultants, volunteers and students.
8. The program provides ongoing training, support and supervision for the development of staff, contract workers, volunteers and students.
9. The program involves families in staff orientation and ongoing development.
10. The program provides appropriate and ongoing reflective supervision for staff.
11. The program has policies and practices that support staff in coping with vicarious trauma in the workplace.
12. Staff participate in program and service delivery decision-making.

13. Staff compensation is fair and equitable within the program and organization, and compared to community standards.
14. The program has staff recognition strategies, of which staff are aware.
15. The program meets staff needs by offering flexibility in the workplace
16. The program has a process to determine, monitor and evaluate workload to ensure that expectations are appropriate.
17. The program provides a climate that encourages staff well-being.
18. The program has written Human Resources policies and procedures that include policies related to safe working environments.
19. Human Resources policies and procedures are reviewed and revised as appropriate on a regular basis (i.e., at a minimum of every two to three years).

CONTENT AREA THREE: HUMAN RESOURCES

Services offered take their shape from the needs of those they serve rather than from the precepts, demands, and boundaries set by professionals. (O.A.I.D. Guiding Principle)

Please rate your program on each Indicator listed in the following Program Self Evaluation Chart. Please remember that the term "staff" refers to all staff, including management.

HUMAN RESOURCES	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. The program has hiring policies that state minimum staff qualifications.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
2. The program employs staff from a variety of educational backgrounds, training, and expertise.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
3. Staff members are included in the hiring process.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
4. The program has written job descriptions which articulate the requirement to work collaboratively with families and define the roles and responsibilities of staff.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
5. Staff reflect a cross section of the community served by the Program.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
6. The program provides for systematic orientation and pre service training of new staff.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

HUMAN RESOURCES	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
7. The program provides for systematic orientation, support, and supervision of volunteers, contract workers, consultants, and students.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
8. The program provides ongoing training, support and supervision for the development of staff, contract workers, volunteers and students.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
9. The program involves families in staff orientation and ongoing development.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
10. The Program provides appropriate and ongoing supervision for staff.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
11. The program has policies and practices that support staff in coping with vicarious trauma in the workplace.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
12. Staff participate in program and service delivery decision-making.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
13. Staff compensation is fair and equitable within the program and organization, and compared to community standards.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

HUMAN RESOURCES	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
14. The program has staff recognition strategies, of which staff are aware.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
15. The program meets staff needs by offering flexibility in the workplace.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
16. The program has a process to determine, monitor and evaluate workload to ensure that expectations are appropriate.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
17, The program provides a climate that encourages staff well-being.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
18. The program has written Human Resources policies and procedures that include policies related to safe working environments.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
19. Human Resources policies and procedures are reviewed and revised as appropriate on a regular basis (i.e., at a minimum of every two to three years).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 44 to record all Indicators rated with ”Immediately” and to Page 46 to record all Indicators rated with “Next 3 Years”.

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record all the Indicators which you have decided need immediate improvement in the Human Resources Content Area.

1.

2.

3.

4.

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Please note: if you decide that there are too many Indicators in this Content Area for immediate work, you could choose to move some of the Indicators to the "Next 3 Years" rating. In that case, make sure to change the Rating on the Program Self Evaluation Chart which precedes this Page. **Please turn to the next page to complete a Planning Form for each Indicator remaining on your list for immediate improvement.**

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2
CONTENT AREA 4 – MODELS OF SERVICE DELIVERY

PHILOSOPHY AND VALUES

Service models typically identify basic principles and structures (including pattern and location of services) used to organize and guide service delivery. Models, for example can differ in

- service location (e.g., home, hospital, clinic, child care center, Ontario Early Years Centre)
- principal focus of intervention (e.g., children birth to sixth birthday, parent-child interaction, family as whole, group)
- contact frequency (e.g., daily, weekly, monthly, as needed)
- service provider training/education (e.g., volunteer, paraprofessional, discipline trained)
- team approach (e.g., multi-, inter-, trans- disciplinary)
- delivery approach (e.g., consultation, mediator training, 1:1 intervention, groups)

O.A.I.D. believes that model of service delivery should reflect the philosophies, strategies, staff, and settings that will provide the best possible opportunity for optimal development through family-centred intervention.

It is not expected that all infant development programs in Ontario should use identical models as there is no one model that is best for all families in all situations (see research below). O.A.I.D. has, however, identified throughout this manual a number of features that should be part of any model of service delivery. These features include

- family-centred approach
- team approach
- individualized and developmentally appropriate services
- comprehensive and coordinated services
- availability of home based and small group services
- congruency with community values and resources

- earliest possible identification and intervention

RESEARCH

Overall, the literature does not support any one model for use in all situations. (Executive Summary, 1999; Hines & Bennett, 1996; Krauss, 1997; Olds et al, 1994; Trivette et al, 1996) Many investigators continue to focus on the cause-effect relationship between specific components of a service model and child and family outcomes. (Bailey et al, 1998; Bruder, 1993; McDonald et al, 1999; Olds et al, 1994; Trivette et al, 1996) Meanwhile, new models and approaches continue to emerge and to be elaborated upon to address changing needs and issues (e.g. Dunst & Trivette, 1997; Editorial, 1994; McDonald et al, 1999; Raab et al, 1993; Trivette et alo, 1996).

Of particular interest is the continuing development of family-centred service models (e.g. Dunst, 1997; Trivette et al, 1997) and the emergence of resource-based approaches to early intervention. Resource based approaches emphasize the use of community resources to strengthen and support family capabilities. (Berlin et al, 1998) Resources are defined as the full range of community help including, for example, information, experiences, opportunities, and people.

Service Delivery

O.A.I.D. recognizes home visiting as a cornerstone of almost all infant development programs in Ontario. A number of benefits have been suggested for home visiting as a method of delivering an early intervention service. For example

- families generally feel more relaxed and comfortable in their own surroundings
- opportunities for participation of all family members may be increased
- staff can experience the family's environment and routines thus designing more useful and practical activities
- staff can model activities in the setting where they will be used
- program access is increased, particularly for families who are without transportation, are geographically isolated, have other young children to care for, or have a child with special health care needs.

Evaluation of home visiting services (in contrast to centre-based service) has been complicated by the diversity of program models, practices and target populations in which home visiting has been applied. (Berlin et al, 1998; Executive Summary, 1999) It has been suggested that home visiting services may be best suited to enhance family well being and parent-child relationship while centre based services may be better at enhancing cognitive and language development. (Berlin et al, 1998) Many investigators

continue to support the efficacy of home visiting. (Olds, 1994; Raab et al, 1993) However, others caution that its effectiveness depends in large part on the needs and characteristics of the individual family and child. It is recognized that some infants/children attend child care or preschool. In such situations, providing service in the child care or preschool setting may compliment home-visiting. At this point in time, the relationship between specific home-visiting practices and child and family outcome is not well understood. (Executive Summary, 1999)

O.A.I.D. fully expects home visiting will remain a hallmark of any service model for Infant Development Programs in Ontario. However, there may be benefits to flexibility in service delivery such as the offering of group-based services.

OAID recognizes that group based services are a part of service delivery in some infant development programs. Group based services include groups for parents, for parents and children together as well as groups for children alone.

A number of benefits have been suggested for group-based services for parents as a method of delivering an early intervention service. These include

- Parents have an opportunity to meet other parents who may be facing similar challenges (Dunst et al, 1997)
- Some families, particularly those at higher socio-economic risk and new immigrant, are more likely to attend a community-based group than agree to home visiting (Cunningham et al, 1995)
- Group-based services can be more efficient, in that one or two clinicians can serve multiple families simultaneously
- Group-based services can cost less than individual service (Niccols, McFadden & Parker, 1996)

When considering models of service delivery to preschoolers, it is important to consider the existing system of service to this population. It is not the intent of this content area to prescribe which services are best for preschoolers, but rather to suggest that linkages and collaboration would be beneficial (for example, with Ontario Early Years Centres, Resource Teacher supported preschools).

Another approach to service delivery is the development of care pathways for specific client groups. This approach uses information from the research literature as well as current clinical practice to determine who needs infant development services, the range and types of services available in each level of service within a pathway, when screening should take place, as well as what assessments are provided, when, and why. An effective care pathway incorporates all of the features of service delivery outlined above, so that the individual needs of clients are met efficiently and effectively.

Research regarding Models of Service Delivery indicates that

- different models of service delivery are effective with different families and the model used should be matched to the family's needs and wishes

BEST PRACTICE INDICATOR

Best Practices in Models of Service Delivery is one basic Indicator that encompasses most of the concepts discussed above.

1. Service delivery options and approaches are selected and adapted to suit the individual family being served (e.g. specific cultural or socio-economic populations or infant/young child risk categories, age of child, focus of intervention).

CONTENT AREA FOUR: MODELS OF SERVICE DELIVERY

The O.A.I.D. Guiding Principles recommend that Models of Service Delivery should reflect a combination of philosophies, strategies, staff, and settings. All are aimed at providing the infant and young child with the best possible opportunity for optimal development.

Please rate your program on each Indicator listed in the following Program Self Evaluation Chart.

MODELS OF SERVICE DELIVERY	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. Service delivery options and approaches are selected and adapted to suit the individual family being served (e.g. specific cultural or socio-economic populations or infant and young child risk categories).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 52 to record this Indicator if rated with "Immediately" and to Page 54 to record this Indicator if rated with "Next 3 Years".

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record the Indicator if you have decided that it needs immediate improvement in the Models of Service Delivery Content Area.

1.

Please turn to the next page to complete a Planning Form for this Indicator if it is on your list for immediate improvement.

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2
CONTENT AREA 5 – SERVICE COORDINATION USING A TEAM APPROACH

PHILOSOPHY AND VALUES

The families of most infants or young children who have special needs, or are at-risk, will use a number of supports from different organizations or services. A team approach is important when working with infants/young children and their families so as to provide the most effective and least intrusive service possible.

Many terms such as case coordination, service facilitation, resource coordination and case management are used interchangeably to describe the coordination of supports and services. Since 1998 the term preferred by the Ministry of Community and Social Services is service coordination. This term recognizes that professionals are now working with parents and families as equal partners in assessment, decision-making and intervention. For further information about service coordination, please see page 19 of the 2001 Ministry Guidelines. (Ministry of Community & Social Services, 2001)

Two essential elements of service coordination are

- the family is an integral team member and final decision-maker
- all team members (including family, professionals, and others) work in a holistic, coordinated manner to support the infant or young child and the family.

Effective service coordination ensures that the service system does not lose sight of the child as an individual, or of the cumulative demands that the services make on parents.

The O.A.I.D. value statement is very clear regarding this Content Area:

O.A.I.D. believes that infant development programs should utilize a family-centred approach to service coordination and service delivery.

To provide service coordination and service delivery, a team approach is required.

In the context of Best Practices, O.A.I.D. defines the following teams

- ✪ The staff from the individual infant development program who support each other
- ✪ The group of professionals (from all involved services) supporting the family who share knowledge and resources, collaborate on strategies and ideas, and support each other

- ✪ The entire group of individuals, who are directly involved in providing resources and supports to the specific infant/young child and family, including informal community and family supports.

All three teams defined above are important. The first two address professional peer support and staff development. These are directly helpful to staff and indirectly helpful to families participating in service. The third team is essential to individual service provision when using a family-centred approach. It is the decision-making team.

Service Coordination is most effective when teams use a transdisciplinary approach. *A transdisciplinary approach* involves the family and professionals. The infant or young child's development is viewed holistically and in the context of the family. Professionals "overcome the confines of individual disciplines to form a team that crosses and re-crosses disciplinary boundaries to maximize communication, interaction, and cooperation among the members". (Feature Article, 1993) This results in what is called "role release" in which one team member carries out the service plan backed by the authorization and consultative support of other team members. This is done in the context of regulatory restrictions and common sense. Professionals benefit from the transdisciplinary approach as it allows them to expand their expertise.

Families also benefit from the transdisciplinary approach because they deal primarily with one professional, who is called the Service Coordinator. This individual coordinates the services of the team, including assessment, planning and implementation. The Service Coordinator is chosen by the family, and may be a family member or professional.

Service coordination is important throughout intervention, and is particularly important when considering transitions to other services and/or discharge from the infant development program. Transition and discharge planning should be an ongoing part of service planning. This helps families to be well prepared for transitions or discharge.

Transition and discharge protocols may include provisions for consultative services for an agreed upon time, as the family transitions to a new service. This will help the child and family through the process.

RESEARCH

There is considerable support for a transdisciplinary approach from a family perspective. (Malfair, 1992; Odom & McEvoy, 1990; Woodruff & McGonigel, 1992) Some of the articles supporting this model reflect research study results, while others are more anecdotal endorsements. It appears to be a particularly effective model where professional resources are constrained due to factors such as an isolated geographical area or funding limitations. It is, however, more difficult to achieve when a number of services are involved, and where different philosophies and policies may pertain.

Research regarding the Team Approach and Service Coordination indicates that

- ✪ a team approach is the most effective method of delivering developmental services for infants and young children
- ✪ maximum service effectiveness results when the team approach is family-centred and holistic
- ✪ families are more satisfied with a transdisciplinary team approach because the family is a respected team member, and the process is less intrusive, as compared to other team approaches such as multidisciplinary or interdisciplinary
- ✪ effective service coordination, where one person is identified as service coordinator, assists in ensuring the system does not lose sight of the child as an individual
- ✪ effective service coordination ensures that the system does not lose sight of the cumulative demands that services make on families

BEST PRACTICE INDICATORS

1. Families participate as team members in service planning and are the key decision makers.
2. Documentation reflects that families are team members who participate in service planning and decision-making (e.g. IFSP, service coordination/case conference notes, and contact notes).
3. The planning process involves clarifying the roles/responsibilities of each agency working with the child/family and the designation of a service coordinator. The family may choose a family member to be the service coordinator.
4. Team members meet regularly for consultation, service coordination, and problem-solving.
5. To facilitate effective service coordination, team members participate in cross-disciplinary training and consultation with internal and external peers.
6. Informed consent is obtained prior to other agencies' involvement in the service coordination process, following applicable regulations.
7. There is a process in place for conflict resolution.
8. Service protocols are developed with partner agencies for the purposes of transition and discharge planning.
9. Transition planning is initiated well in advance of discharge.

CONTENT AREA FIVE: TEAM APPROACH AND SERVICE COORDINATION

Early intervention services should support the family as an integral team member and the final decision maker. Collaborative partnerships with other community service providers should be included (O.A.I.D. Guiding Principle).

Please rate your program on each Indicator listed in the following Program Self Evaluation Chart.

TEAM APPROACH AND SERVICE COORDINATION	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. Family participate as team members in service planning and are the key decision makers.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
2. Documentation reflects that families are team members who participate in service planning and decision making (e.g. IFSP, case conference notes, and contact notes).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
3. The planning process involves clarifying the roles/responsibilities of each agency working with the child/family and the designation of a service coordinator. The family may choose a family member to be the service coordinator.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
4. Team members meet regularly for consultation, case review, and problem solving.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

TEAM APPROACH AND SERVICE COORDINATION	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
5. To facilitate effective service coordination, staff members participate in cross disciplinary training and consultation with internal and external peers.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
6. Informed consent is obtained prior to other agencies' involvement in the service coordination process, following applicable regulations.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
7. There is a process in place for conflict resolution.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
8. Service protocols are developed with partner agencies for the purposes of transition and discharge planning.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
9. Transition planning is initiated well in advance of discharge.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 60 to record all Indicators rated with "Immediately" and to Page 62 for "Next 3 Years".

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record all the Indicators which you have decided need immediate improvement in the Team Approaches Content Area.

1.

2.

3.

4.

Please note: if you decide that there are too many Indicators in this Content Area for immediate work, you could choose to move some of the Indicators to the "Next 3 Years" rating. In that case, make sure to change the Rating on the Program Self Evaluation Chart which precedes this Page. **Please turn to the next page to complete a Planning Form for each Indicator remaining on your list for immediate improvement.**

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2
CONTENT AREA 6 – SCREENING & ASSESSMENT

PHILOSOPHY AND VALUES

Screening and assessment are important facets of infant development service. Screening tools can be differentiated from surveillance tools for example, the Nipissing Developmental Screen (Nipissing District Developmental Screen, 1996), and Parents Evaluation of Developmental Status, as the latter are used primarily to identify children who require further screening or assessment. Information obtained can be used for a variety of purposes. Screening is used to determine eligibility and the need for further evaluation. Screening tools may be used as part of an assessment, but are not sufficient for diagnosis and may not be sufficient for measuring change. Assessment is used for diagnosis, identifying goals and interventions, and measuring change. It is critical that the screening/assessment process be individualized according to the unique needs of the child and family. This includes consideration of cultural, ethnic and linguistic backgrounds and the potential bias of screening/assessment tools.

Assessment is an ongoing collaborative process to gather information from multiple sources in order to make decisions. Within the context of infant development, this includes direct observation of the child's play, interaction with family members/caregivers, and assessment of the child's skills in different developmental domains.

From the perspective of O.A.I.D. Best Practices, it is important to consider **both** the technical process of screening/assessment **and** the values that underlie these processes. Thus, the screening/assessment should

- be family-centred
- consider the infant or young child holistically
- be conducted in accordance with legal and ethical standards
- utilize the techniques and tools which reflect the current state of the art

Combining technical skill and ethical practice is, in essence, the definition of a human service professional.

Screening or assessment is one of the first "official" intervention related activities that the staff and family engage in. The way in which the professional approaches the screening/assessment will definitely establish the pattern for the future relationship between the family and staff. The family will know very quickly if the professional values the family's input and views them as the experts on their infant or young child.

The O.A.I.D. value statement regarding Screening and Assessment indicates the recommended approach to the process.

O.A.I.D. believes that the screening and assessment processes that infant development programs engage in should be collaborative, ongoing, and incorporate active parental involvement.

It is necessary to note that screening/assessment looks beyond the infant/young child as an individual and sees the infant/young child in the context of the family. If the context of the family is not taken into account during the assessment process, there is the risk of inappropriate recommendations or strategies. The process of developing goals should be collaborative and it is essential to obtain the agreement of parents to any goals that are developed for the infant or young child. (Bagnato et al, 1989) In fact, the parents' concerns regarding the infant or young child should be addressed first. These are usually the issues that are most important for the family as a unit and thus are the ones that parents will consider to be a priority. (Bagnato & Neisworth, 1999)

Therefore, useful screening or assessment considers three aspects:

- the infant or young child's competencies and needs
- the family's needs and the family's resources that can be activated or expanded to address the infant's or young child's needs
- the infant or young child's bond or relationship to family members

In this way, the family and the infant/young child are mutually strengthened.

RESEARCH

There is considerable research regarding the effectiveness of particular assessment tools that can be helpful to the professional who is considering what s/he should use to conduct an assessment. When deciding upon specific screening or assessment tools, the decision needs to be based on current reliability and validity information for each test. Such information is helpful in determining whether the tool is the most appropriate given the age of the child, the weaknesses exhibited and the purpose for the evaluation. This section will not review specific screening/assessment tools. Instead, it addresses research into the process of screening/assessment with regards to the family-centred approach, which is the foundation for O.A.I.D. Best Practices.

No single screening or assessment tool can provide all the developmental information needed. Certain tools may be more appropriate in some cases than others. Program staff need to be familiar with a variety of screening and assessment tools, and be able to choose those that will

- serve the purposes of assessment
- reflect the individual assessment needs of the infant or young child
- accommodate the expertise and professional training of the program staff (Ministry of Community & Social Services, 2001)

In addition to evaluating the infant or young child's strengths and weaknesses, it is important to evaluate the relationship between the parent/caregiver and the infant/young child. The nature of this relationship plays an important role in determining outcomes.

Many authors have discussed the importance of parental involvement in the assessment process. For example, Meisels and Shonkoff indicate that "active parental involvement in the assessment process is necessary to achieve therapeutic results". (Meisels & Shonkoff, 1990) Not only is parental involvement something we believe is the right thing to do, it is also the effective thing to do as it contributes to the success of the developmental program.

We must also acknowledge that families have the right to determine the extent of their involvement in the assessment process. More recently, this concept of parental involvement in assessments has been expanded. Many professionals now use the family directed assessment model, in which the parents are not only involved, but they direct the process. (Berman et al, 1994) This is congruent with the O.A.I.D. family-centred approach to service delivery.

There are some conclusions that can be drawn from the research.

Research regarding Screening and Assessment indicates that

- ❖ Parental involvement is essential to both the screening or assessment processes
- ❖ Screening or assessment of infants and young children should be individualized
- ❖ The competencies and needs of both the infant/young child, the family and infant-caregiver relationship must be determined and used when developing programs

Best Practices in Screening and Assessment reflect both the family-centred approach and technical requirements.

1. Informed consent is obtained for the gathering and sharing of all information.
2. The family is involved in determining when or if the screening/assessment should take place.
3. When planning screening or assessment, infant development staff consider the infant's or young child's temperament, personality, learning style, language and culture.
4. Screening/assessment is a collaborative process and when appropriate, information is gathered from multiple sources (e.g. family members, other agencies, and professionals).
5. When conducting a comprehensive assessment, a variety of measurement tools (including criterion and norm referenced tools as appropriate) should be used. A comprehensive assessment should consider developmental information, caregiver-child interaction and knowledge and attitude of the parents/caregivers.
6. Caregivers and infant development staff determine the appropriate level of participation by all involved (e.g. observer, informant, participant) in the screening/assessment process.
7. In any screening/assessment process, parents have the opportunity to contribute information on the infant's or young child's abilities, needs and background. With appropriate consent, other caregivers may also have the opportunity to provide this type of information.
8. Formal developmental assessments of infants and young children (using standardized tools and leading to a written report) are administered when clinically indicated.
9. Screening and assessment tools are administered and interpreted by appropriately trained and qualified staff. When resources are not available within the infant development program, a referral will be made for an external consultation or assessment.
10. Assessment results will be considered when developing goals and plans.
11. There is a process to evaluate change in the infant's and young child's development. This process may include screening and assessment.
12. The family reviews assessment reports before they are finalized.
13. Families receive a copy of reports written by program staff in a timely manner.

CONTENT AREA SIX: SCREENING AND ASSESSMENT

Assessment is an ongoing process designed to enhance a service provider's understanding of a infant's or young child's competencies and support needs and the family's resources in addressing those needs (O.A.I.D. Guiding Principle).

Please rate your program on each Indicator listed in the following Program Self Evaluation Chart.

SCREENING AND ASSESSMENT	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. Informed consent is obtained for the gathering and sharing of all information.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
2. The family is involved in determining when or if the screening/assessment should take place.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
3. When planning screening or assessment, infant development staff consider the infant's or young child's temperament, personality, learning style, language and culture.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
4. Screening/assessment is a collaborative process and when appropriate, information is gathered from multiple sources (e.g., family members, other agencies, and professionals).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

SCREENING AND ASSESSMENT	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
5. When conducting a comprehensive assessment, a variety of measurement tools (including criterion and norm referenced tools as appropriate) should be used. A comprehensive assessment should consider developmental information, caregiver-child interaction and knowledge and attitude of the parents/caregivers.	Never Rarely Sometimes Usually Always 0% 25% 50% 75% 100%	Yes No	Immediately Next 3 Years
6. Caregivers and infant development staff determine the appropriate level of participation by all involved (e.g., observer, informant, participant) in the screening/assessment process.	Never Rarely Sometimes Usually Always 0% 25% 50% 75% 100%	Yes No	Immediately Next 3 Years
7. In any assessment process, parents have the opportunity to contribute information on the infant's or young child's abilities, needs and background. With appropriate consent, other caregivers may also have the opportunity to provide this type of information.	Never Rarely Sometimes Usually Always 0% 25% 50% 75% 100%	Yes No	Immediately Next 3 Years

SCREENING AND ASSESSMENT	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
8. Formal developmental assessments of infants and young children (using standardized tools and leading to a written report) are administered when clinically indicated.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
9. Screening and assessment tools are administered and interpreted by appropriately trained and qualified staff. When resources are not available within the infant development program, a referral will be made for an external consultation or assessment.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
10. Assessment results will be considered when developing goals and plans.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
11. There is a process to evaluate change in the infant's and young child's development. This process may include screening and assessment.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
12. The family reviews assessment reports before they are finalized.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

SCREENING AND ASSESSMENT	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
13. Families receive a copy of reports written by program staff in a timely manner.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 71 to record all Indicators rated with ”Immediately” and to Page 73 to record all Indicators rated with “Next 3 Years”.

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record all the Indicators which you have decided need immediate improvement in the Assessment Content Area.

1.

2.

3.

4.

5.

6.

7.

8.

Please note: if you decide that there are too many Indicators in this Content Area for immediate work, you could choose to move some of the Indicators to the "Next 3 Years" rating. In that case, make sure to change the Rating on the Program Self Evaluation Chart which precedes this Page. **Please turn to the next page to complete a Planning Form for each Indicator remaining on your list for immediate improvement.**

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2

CONTENT AREA 7 – PROGRAM EVALUATION

PHILOSOPHY AND VALUES

Program evaluation "can be defined as the systematic, objective process of examining the quality of services" provided by the particular program. (Mitchell, 1991) The primary question to be asked is: What do we mean by 'quality of services"?

Of course, there is considerable focus today on quality, with several thousand books and articles purporting to have the best approach to defining and measuring this elusive concept. It is not our intention to address the issue of defining quality per se. Instead, O.A.I.D. is suggesting that quality of service would be achieved by carrying out these Best Practices. Furthermore, carrying out these Best Practices is likely to enhance the quality of life experienced by families.

There are three essential components to the Content Area of Program Evaluation:

- Program Evaluation must be conducted in a manner which reflects a family-centred philosophy
- Program Evaluation must include an analysis of outcomes expected as a result of working with families
- Program Evaluation should be conducted in a manner which uses the highest known standards of technical competence

Therefore, Program Evaluation investigates how a program conducts its business and the end results of its efforts. Thus there is a twin focus on process as well as product.

The O.A.I.D. value statement for Program Evaluation emphasizes that early intervention plays an important role in enhancing a family's quality of life. Quality of service should be determined by the extent to which family-centred practices respond to the family's needs and priorities rather than solely on compliance with professional standards, policies, and procedures.

O.A.I.D. believes that infant development programs should be evaluated on their ability to enhance the quality of life of the infant or young child and the family, with quality being defined by the family.

There are several components that should be included in a comprehensive evaluation of early intervention services:

- family-centred practice
- professional standards and accountability
- cultural sensitivity
- fiscal and human resource management
- occupational health and safety
- planning
- program impact on the infant/young child, family, and community
- standards of Best Practice

Therefore, the entire service delivery system of the program is the focus of the Program Evaluation. In keeping with the family-centred approach, family feedback should be a primary source of evaluation data and a variety of techniques should be employed to ensure that this feedback is obtained. This can include collecting both written and verbal information from families and doing so at different stages of the service process.

RESEARCH

Research into Program Evaluation can become quite technical as it discusses various aspects of the methodology. For the purposes of these Best Practices, it is most useful to consider the research results that apply to the overall process, rather than the specific techniques. (Mitchell, 1990; Mitchell, 1991)

Bailey and his colleagues suggest that early intervention programs must ask themselves if their services have indeed enabled the family to help the infant or young child develop ***and*** have supported the family as a whole to achieve a better quality of life. (Bailey et al, 1998) They have created a series of questions that an agency can utilize to evaluate its success in achieving family outcomes through its service provision. The first set of questions focuses on the family's perception of appropriateness, responsiveness, and effectiveness of the services. The second set of questions investigates the extent to which early intervention fostered the parents' perceived competence as caregivers, the building of strong support systems, their ability to work with professionals, and their optimism about the future. This is a strong endorsement of the family-centred, holistic approach to early intervention services.

Research results regarding Program Evaluation indicate that

- ✪ Program Evaluation must investigate how services are delivered and the outcomes produced by these services
- ✪ It is recommended that Program Evaluation be conducted regularly on an established schedule

BEST PRACTICE INDICATORS

Best Practices in Program Evaluation consider both the process and product of the program's services.

1. The program has participated within the past four years in an (**external**/formal) accreditation process, a peer review, or a Ministry review that included a written evaluation with identified findings, conclusions, and recommendations.
2. The program conducts (at a minimum) a yearly **internal** review of operating standards, practices, procedures and policies that documents ongoing quality improvement initiatives.
3. The program ensures that families not only have opportunities to provide input into the development of the program (e.g. focus groups, questionnaires, face to face interviews, phone interviews, and committee memberships) but, as well, into the development of the program's evaluation methods and tools.
4. The program enables families to have input into strategic planning, quality improvement, and program development (e.g. focus groups, questionnaires, face to face interviews, and committee memberships).
5. There is a process to obtain feedback from families on the program outcomes and satisfaction with services throughout service delivery.
6. The evaluation process includes collecting both quantitative and qualitative data.
7. There is a process through which families can express concerns or complaints and families are made aware of this process.
8. The program has a way of incorporating family concerns or complaints into its evaluation and planning processes.bb

CONTENT AREA SEVEN: PROGRAM EVALUATION

Early intervention plays a critical role in enhancing the quality of life of infants and toddlers with special needs and their families. Program Evaluation addresses questions about program policies, practices, processes, and outcomes. (O.A.I.D. Guiding Principle).

Please rate your program on each Indicator listed in the following Program Self Evaluation Chart.

PROGRAM EVALUATION	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. The Program has participated within the past four years in an (**external**/formal) accreditation process, a peer review or Ministry review that included a written evaluation with identified findings, conclusions, and recommendations.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
2. The Program conducts (at a minimum) a yearly **internal** review of operating standards, practices, procedures and policies which documents ongoing quality improvement initiatives.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

PROGRAM EVALUATION	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
3. The Program ensures that families not only have opportunities to provide input into the development of program evaluation (e.g. focus groups, questionnaires, face to face interviews, phone interviews, and committee memberships), but as well, into the development of the program's evaluation methods and tools.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
4. The Program enables families to have input into strategic planning, quality improvement, and program development (e.g. focus groups, questionnaires, face to face interviews, phone interviews, and committee memberships).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
5. There is a process to obtain formal feedback from families on program outcomes and satisfaction with services throughout service delivery.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
6. The evaluation process includes collecting both quantitative and qualitative data.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

PROGRAM EVALUATION	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
7. There is a process through which families can express concerns or complaints and families are made aware of this process.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
8. The Program has a way of incorporating family concerns or complaints into its evaluation and planning processes.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 80 to record all Indicators rated with ”Immediately” and to Page 82 to record all Indicators rated with “Next 3 Years”.

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record all the Indicators which you have decided need immediate improvement in the Program Evaluation Content Area.

1.

2.

3.

4.

5.

6.

7.

Please note: if you decide that there are too many Indicators in this Content Area for immediate work, you could choose to move some of the Indicators to the "Next 3 Years" rating. In that case, make sure to change the Rating on the Program Self Evaluation Chart which precedes this Page. **Please turn to the next page to complete a Planning Form for each Indicator remaining on your list for immediate improvement.**

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2
CONTENT AREA 8 – COMMUNITY BUILDING

PHILOSOPHY AND VALUES

The Community Building Content Area considers a broader and longer-term perspective than is typical of most infant development Best Practices. Certainly it is essential to create individual infant/young child and family goals that can be accomplished within a relatively short time frame and that meet immediate needs.

However, infant development services must terminate when the child reaches a specific age. How can these services best be provided to ensure that gains made during the program will last in some meaningful way? As was discussed in the Introduction, a family-centred approach that incorporates a community perspective is one answer to this question.

To begin with, it is useful to consider what is meant by community. Community can certainly have a geographical connotation, but Community Building refers to something more complex. A community is people who come together for some particular purpose. (Trivette et al, 1997) There can be many types of communities – geographical neighbourhoods, places of employment, places of worship, educational institutions, clubs, child care centres, sports teams, etc. People of all ages belong to multiple communities.

The most enjoyable and fulfilling lifestyle is one of participation and integration into the community. Infant development programs have always recognized that all individuals have the right to participate fully and effectively in their chosen communities. Community Building extends the concept of integration into a broader perspective in which the community itself is strengthened to better incorporate and support all families.

Community Building is a strengths-based approach in which individuals are supported to recognize their community's assets and to develop what they want in their community utilizing these assets. The community members are the leaders, while professionals fulfill a facilitative function.

Family-centred service incorporates community. Dunst and Trivette conceptualize the child's universe as being comprised of three sources of learning opportunities: Family Life, Community Life, and Early Childhood Programs. (Dunst et al, 1999) The role of the practionner is to provide structured learning opportunities and to use/expand learning opportunities provided by both the family and the community. "A lesson learned from extensive observations and interviews with parents is that identifying natural learning environments requires that practionners 'think outside the box' and take the time to listen to families' descriptions of their home and community lives, and to

understand the value and importance of child participation in naturally occurring learning environments as sources of learning opportunities". (Ibid)

However, this is not just a matter of using what the community has to offer. It is also important to enhance the community, not only for the good of all its members, but also to the specific benefit of the infant/young child and the family.

"A healthy society is built on strong families and communities and not on families alone." (Sviridoff & Ryan, 1997) Strong families mean strong children and strong communities mean strong families. Emphasizing this point, Bailey and his colleagues have stated that building a stronger community is a valid outcome for service delivery and should be incorporated into service evaluation. (Bailey et al, 1998)

Therefore, Community Building is a legitimate aspect of an infant development program. It incorporates two key facets:

- infant development programs should support families and their infant or young child to become contributing community members since relationships beyond the nuclear family are essential if a family is to have a broad base of support that extends beyond paid service providers

- infant development programs should support communities to become more competent and inclusive

O.A.I.D. believes that infant development programs should support the development of individual, family, and community capacities.

Community Building Best Practices reflect the fact that staff should conduct development on both the individual level and community level. This is the most effective way of ensuring that the gains made by infants and young children and families participating in an infant development service are not lost when the infant or young child graduates, but instead contribute to ongoing quality of life.

Many different activities can be part of Community Building:

- teaching families advocacy skills

- providing families with information regarding the community

- working with other service providers to enhance service delivery

- seeking out and strengthening natural supports and linkages

- providing culturally sensitive services

- educating the community
- consulting to other services and professional groups
- supporting the development of community groups
- supporting community efforts to reduce crime, provide affordable housing, increase employment, etc.

Clearly, to conduct successful Community Building, staff must have a variety of skills beyond their professional training related to infant development ***and*** they must believe in the validity of conducting such activities. Staff training should include community building skills, as well as therapeutic skills.

RESEARCH

Although many people have commented on the decline of our communities, and the negative impact that this decline has on our citizens, none has been as eloquent as McKnight. (Kretzmann & McKnight, 1993; McKnight, 1997) He clearly states that local structures (i.e. the elements of the local community) are vital components of any process that seeks to be effective in addressing any type of social problem. In particular, he believes that by regenerating communities, we could reawaken each community's capacity to support all citizens, including those with vulnerabilities. His personal goal is to decrease our reliance on formal human services, which he states segregate and diminish the capacities of its "clients".

While not all authors would agree with McKnight's position on the negative impact of professionally delivered services, most would support his belief in the need to regenerate communities. The research literature has many reports of successful projects that have promoted client growth and success through community building. There are several important results that have been noted:

- The "problems" of individuals are really "whole community problems" – to support people effectively we must acknowledge the communal dimensions of their individual problems. (Feikema et al, 1997)
- The empowerment approach looks upon the community as a resource to be developed ***with*** families, not ***for*** families. (Sviridoff & Ryan, 1997)
- Supports should be delivered within people's communities and within their existing networks in order to strengthen communities. (Webster-Strattion, 1997)
- The positive impact of community building is consistent both for infants and young children with biological risks and those with environmental risks. (Guralnick, 1998)

- To be effective, an early intervention program should provide referral and linkages to a range of community resources that will support the family to deal more effectively with all their stressors, including those which are societal in nature. (Ibid)

Research regarding Community Building indicates that

- ✪ Community Building is an essential component of infant development services
- ✪ Community Building enhances both the short term and long term effectiveness of services delivered to maximize the development of the infant and young child

BEST PRACTICE INDICATORS

Best Practices in Community Building incorporate the building of both family competencies and community capacity.

1. The program assists families to advocate for service development in the community by encouraging parents to participate on community committees, focus groups, in letter writing, etc.
2. The program assists families by encouraging peer support and/or mentoring models.
3. The program is involved in and supports collaborative activities with community-based groups (e.g. community committees or focus groups).
4. The program takes part in larger community planning projects (e.g. multi-agency service projects).
5. The program has written protocols with community agencies to facilitate provision of services and transitions.
6. The program participates in a community process to simplify access to services.
7. The program participates in community education and advocacy (e.g. information fairs or workshops/presentations).
8. The program supports a community building approach and recognizes the necessity of community inclusion for both the child and family.

CATEGORY EIGHT: COMMUNITY BUILDING

Community Building involves the shared responsibility of the family and the Program to build on the community's innate capacity to support individuals and groups.

Please rate your Program on each Indicator in the following Program Self Evaluation chart:

COMMUNITY BUILDING	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
1. The program assists families to advocate for service development in the community by encouraging parents to participate on community committees, focus groups, letter writing, etc.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
2. The program assists families by encouraging peer support and/or mentoring models.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
3. The program is involved in and supports collaborative activities with community-based groups (e.g. community committees or focus groups).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
4. The program takes part in larger community planning projects (e.g. multi-agency service projects).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
5. The program has written service protocols with partner agencies to facilitate provision of services and transitions.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

COMMUNITY BUILDING	HOW OFTEN DOES THIS HAPPEN IN YOUR PROGRAM?	NEED TO IMPROVE?	IF YES, WHEN WILL WE WORK ON THIS?
6. The Program participates in a community process to simplify access to services.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
7. The Program participates in community education and advocacy (e.g. information fairs or workshops/presentations).	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years
8. The Program supports a community building approach and recognizes the necessity of community inclusion for both the child and family.	Never 0% Rarely 25% Sometimes 50% Usually 75% Always 100%	Yes No	Immediately Next 3 Years

Please turn to Page 89 to record all Indicators rated with ”Immediately” and to Page 91 to record all Indicators rated with “Next 3 Years”.

LIST OF ALL INDICATORS WHICH HAVE BEEN RATED FOR IMMEDIATE IMPROVEMENT

Record all the Indicators which you have decided need immediate improvement in the Community Building Content Area.

1.

2.

3.

4.

5.

6.

7.

Please note: if you decide that there are too many Indicators in this Content Area for immediate work, you could choose to move some of the Indicators to the "Next 3 Years" rating. In that case, make sure to change the Rating on the Program Self Evaluation Chart which precedes this Page. **Please turn to the next page to complete a Planning Form for each Indicator remaining on your list for immediate improvement.**

PLANNING FOR CHANGE

Content Area: _____ **Time Frame:** _____

Indicator: _____

Goal: _____

Barriers: _____

STRATEGIES	TASKS	PERSON(S) RESPONSIBLE	TARGET DATE	COMMENTS

INDICATORS REQUIRING FUTURE WORK

CONTENT AREA: _____

INDICATORS

Indicators Rated Within "Next 3 Years"	Date Recorded on this Form	Date Activated for Planning

SECTION 2
BIBLIOGRAPHY

Administration for Children & Families. (2002). Reflective Supervision. http://www.headstartinfo.org/publications/hsbulletin73/hsb73_32.htm Accessed October, 2006.

Affleck, G. Tennen, H., Rowe, J., Rosher, B., & Walker, L. (1989). Effects of Formal Support on Mothers' Adaptation to the Hospital-to-Home Transition of High-Risk infants: the Benefits and Costs of Helping. Infant and young child Development, 60, 488 - 501.

Bagnato, S. J., Neisworth, J.T., & Munson, S.M. (1989). Linking Developmental Assessment and Early Intervention: Curriculum-based Prescriptions, 2nd Edition. Rockville, MD: Aspen.

Bagnato, S., & Neisworth, J.T. (1991) What is Unique About Working with Infants? In: Assessment for Early Intervention: Best Practices for Professionals, Guilford Press.

Bagnato, S.J. & Neisworth, J.T. (1999) Collaboration and teamwork in assessment for early intervention, Child and Adolescent Psychiatric Clinics of North America, 8(2), 347-363.

Bailey, D. B. Jr., McWilliam, R., Aytch Darkes, L., & Hebbeler, K. (1998). Family Outcomes in Early Intervention: A Framework for Program Evaluation and Efficacy Research. Exceptional Children, 64(3), 313-328.

Berlin, L. J., O'Neal, C.R., & Brooks-Gunn, J. (1998). What Makes Early Intervention Programs Work? The Program, Its Participants, and Their Interaction. Zero to Three, 18(4), 4 - 15.

Berman, C. (1994). Family-directed Evaluation and Assessment under the Individuals with Disabilities Education Act (IDEA): Lessons Learned from Experiences of Program and Parents. Zero to Three, 14(6), 16-22.

Brewer, E.J. Jr., McPherson, M., Magrab, P.R., & Hutchins, V.L.(1989). Family-centred, community-based, coordinated care for children with special health care needs. Pediatrics, 83, 1055 - 1060.

Bruder, M. B. (1993). The Provision of Early Intervention and Early Childhood Special Education Within Community Early Childhood Programs: Characteristics of Effective Service Delivery. Topics in Early Childhood Special Education, 19(37), 19-

Centre for Childhood Disability Research. http://www.canchild.ca/ Accessed September, 2006

Centre for Program Excellence (2002). Introducing Reflective Supervision into an Infant/Family Program. http://www.zerotothree.org/cpe/tip_2002_04.html Accessed October, 2006.

Cunningham, C.E., Bremner, R., & Boyle, M. (1995). Large group community-based parenting programs for families of preschoolers at risk for disruptive behaviour disorders: Utilization, cost effectiveness, and outcome. Journal of Child Psychology and Psychiatry, 35, 1141-1159.

DEC Task Force on Recommended Practices (1993). DEC Recommended Practices: Indicators of Quality in Programs for Infants and Young Children with Special Needs and Their Families. Pittsburgh, PA: Division for Early Infant and young childhood Council for Exceptional Infant and young children.

Dunst, C. J. & Trivette, C. M. (1997). Early Intervention with Young At-risk Children and their Families. In Ammerman, R. & Hersen, M. (Eds.). Handbook of Prevention and Treatment with Children and Adolescents: Interventions in the Real World. New York, NY: John Wiley and Sons.

Dunst, C. J. (1997). Conceptual and Empirical Foundations of Family-centred Practice. In Illback, R. et al (Eds.). Integrated Services for Children and Families: Opportunities for Psychological Practice. Washington, D. C.: American Psychological Association

Dunst, C. J. (1998). Identifying and Building on Child, Family and Community Assets. Paper prepared for the Hilton Head Summer Institute, Hilton Head, SC, July 9, 1998.

Dunst, C. J. (1994). Supporting and Strengthening Families in Early Intervention: What Have We Learned?. In Moore, T. (Ed.). Partnership in Practice: Strengthening Relationships in Early Intervention Services. Melbourne, Australia: Australia Early Intervention Association, Victorian Chapter.

Dunst, C. J. , & Bruder, M.B. (1999). Increasing children's learning opportunities in the context of family and community life. Children's Learning Opportunities Report, 1(1). Retrieved August 2005, from http://www.everydaylearning.info/lov1-1.php

Dunst, C. J. et al (1999). Natural Learning Environments for Infants, Toddlers and Preschoolers With or At-Risk for Delays. (Submitted for publication, January, 1999).

Dunst, C.J., Bruder, M.B., Trivette, C.M., Raab, M., & McLean, M. (2001). Natural learning opportunities for infants, toddlers, and preschoolers, Young Exceptional

Children, 4(3), 18-25.

Dunst, C.J., Bruder, M.B., Trivette, C.M., Raab, M., & McLean, M. (2001). Natural learning opportunities for infants, toddlers, and preschoolers, Young Exceptional Children, 4(3), 18-25.

Editorial (1994). The Role of Home Visits in Early Childhood Settings. Resources in Early Infant and Young Childhood Education, 4-5.

Executive Summary (1999). Home Visiting: Recent Program Evaluations. The Future of Children, 9, Spring/Summer. (A special issue devoted to Home Visiting)

Feature Article (1993). Early Intervention Team Approaches: the Transdisciplinary Model. O.A.I.D. Newsletter, Summer, 7-26.

Feikema, R. J., Segalavich, J.H., & Jeffries, S.H. (1997). From Child Development to Community Development: One Agency's Journey. Families in Society: The Journal of Contemporary Human Services, 78(2),185-195.

Glascoe, F.P. (1997) Parents Evaluation of Developmental Status (PEDS). Ellsworth and Vandermeer Press, Nashville, Tennessee, URL: http://edge.net/~evpress. Accessed March, 1999

Guralnick, M. J. (1998). Effectiveness of Early Intervention for Vulnerable Children: A Developmental Perspective. Mental Retardation, 102-4, 319 – 345

Hines, S. & Bennett, F. (1996). Effectiveness of Early Intervention for Children with Down Syndrome. Mental Retardation and Developmental Disabilities Research Reviews, 2, 96 - 101.

Krauss, M. W. (1997). Two Generations of Family Research in Early Intervention. In M. Guaralnick (ED.). The Effectiveness of Early Intervention. Baltimore, MD: Paul H. Brookes.

Kretzmann, J. P. and McKnight, J. L. (1993). Building Communities from the Inside Out. Chicago, IL: ACTA Publications.

Law, M., Rosenbaum, P., King, G., King, S., Burke-Gaffney, J., Moning, T., Kertoy, M., Pollock, N., Viscardis, L., Teplicky, R. (2003). FCS Sheet #01 What is family-centred service? Available: http://canchild.ca. Accessed June 14, 2006

Mahoney, G. Boyce, G., Fewell, R., Spiker, D., Wheeden, C.A. (1998). The Relationship of Parent-Child Interaction to the Effectiveness of Intervention Services for At-Risk Children and Children with Disabilities. Topics in Early Childhood Special Education, 18-1, 5-17.

Malfair, A. (1992). Supporting the Child with Special Needs. The Canadian Nurse, December, 17-19.

McCain, M. and Mustard, J. F., Co-Chairs (1999). Reversing the Real Brain Drain: Early Years Study. Toronto, Ontario: The Centre for Advanced Research.

McCune, L., Kalmanson, B., Fleck, M., Glazewski, B., & Sillari, J. (1990). An interdisciplinary model of infant assessment, In: Meisels, S.J., & Shonkoff, J.P. (Eds.), Handbook of early childhood intervention. New York: Cambridge University Press, pp219-245.

McDonald, L., Kysela, G., Drummond, J., Alexander, A., Enns, R., & Chambers, J. (1999). Using the family adaptation model to facilitate individual family planning. Developmental Disabilities Bulletin, 27, 16 - 29.

McKnight, J. L. (1997). A 21st Century Map for Healthy Communities and Families. Families in Society, March/April, 117 - 127.

Meisels, S.J. & Atkins-Burnett, S. (2000). The elements of early childhood assessment, In J.P. Shonkoff, & S.J. Meisels (Eds.), Handbook of Early Childhood Intervention). New York: Cambridge University Press.pp. 231-257

Meisels, S.J. & Shonkoff, J. P., (Eds.). (1990). Handbook of Early Childhood Intervention. Cambridge, MA: Cambridge University Press.

Ministry of Community and Social Services (1977). Infant Stimulation Guidelines. Toronto, ON: The Queen's Printer.

Ministry of Community and Social Services (1987). Infant Development Program Guidelines. Toronto, ON: The Queen's Printer.

Ministry of Community and Social Services (2001). Guidelines for Ontario's Enhanced/Expanded Infant Development Programs, Toronto, ON: The Queen's Printer.

Mitchell, D. R. (1990). Designing and Evaluating Early Intervention Programmes. In D. R. Mitchell & R. I. Brown (Eds.). Early Intervention Studies for Young Children With Special Needs. London: Chapman Hall.

Mitchell, D. R. (1991). Scale for Evaluating Early Intervention Programmes. Hamilton, New Zealand: University of Waikato.

Niccols, A., McFadden, S., & Parker, L. (1996). Evaluation of an 8-week skill building group for parents of infants at developmental risk. Paper presented at the Zero to

Three National Training Institute and Conference, Washington, D.C. December, 1996.

Nipissing District Developmental Screen (1996). Nipissing District Developmental Screen. North Bay, ON.

North Bay District Health Unit Healthy Babies. (1997). Nippising District Developmental Screen. Availbale: www.ndds.ca

Odom, S. L. & McEvoy, M. (1990). Mainstreaming at the Preschool Level: Potential Barriers and Tasks for the Field. Topics in Early Infant and young childhood Special Education, 10(2), 48-61.

Olds, D. L., Henderson, C., & Kitzman, H. (1994). Does Prenatal and Infancy Home Visitation Have Enduring Effects on Qualities of Parent Caregiving and Child Health at 25 to 50 Months of Life? Pediatrics, 93(1), 89-97.

Program and Professional Advisory Committee, Association of Treatment Centres of Ontario (1995). A Perspective on Family-Centred Service. Toronto, ON: Association Children's Treatment Centres.

Raab, M. M., Davis, M.S., & Trepanier, A.M. (1993). Resources Versus Services: Changing the Focus of Intervention for Infants and Young Children. Infants and Young Children, (1), 1-11.

Raver, S. A. and Kilgo, J (1991). Effective Family-Centred Services: Supporting Family Choices and Rights. Infant Toddler Intervention, 1(3), 169 - 176.

Sajaniemi, N., Makela, J., Salokorpi, T., von Wendt, L., Hamalainen, T., & Hakamies-Blomqvist, L. (2001) Cognitive performance and attachment patterns at four years of age in extremely low birth weight infants after early intervention. European Child and Adolescent Psychiatry, 10, 122-129.

Squires, J., Nickel, R.E., & Eisert, D. (1996). Early detection of developmental problems: Strategies for monitoring young children in the practice setting, Developmental and Behavioral Pediatrics, 17(6), 420-427.

Sviridoff, M. & Ryan, W. (1997). Community-Centred Family Service. Families in Society (72), 128 - 139.

The American Heritage Dictionary of the English Language, 3rd Edition (1992). New York, NY: Houghton Mifflin Company.

The IMP Task Force on Vicarious Trauma in the Workplace (2004). Supporting Practitioner Effectiveness with Young Children in High-Risk Families.

The TASK Project (1990). Preparing Practitioners to Work with Infants, Toddlers and Their Families: Issues and Recommendations for Parents. Arlington, VA: The National Center for Clinical Infant Programs.

Trivette, C. M. Dunst, C.J., Hamby, D.W, & LaPointe, N. (1996). Key Elements of Empowerment and Their Implications for Early Intervention. Infants and Toddler Intervention: The Transdisciplinary Journal,6, 59-73

Trivette, C. M., Dunst, C., & Deal, A. (1997). Resource-based Approach to Early Intervention. In Thurman, S. K. et al (Ed.). Contexts of Early Interventions: Systems and Settings. Baltimore, MD: Paul H. Brookes.

Webster-Stratton, C. (1997). From parent training to community building. Journal of Contemporary Human Services, Families in Society, 78(2), 156 - 171.

Woodruff, G. & McGonigel, M. J. ((1992). Early Intervention Team Approaches: The Transdisciplinary Model, 2nd Edition.

SECTION FIVE:

APPENDICES

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Original Task Force Members
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- Katherine Dracup-Harris, volunteer, co-chair
- Laura Grace, Durham Infant Development Services
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- Cattis Esbensen, Lanark County Infant Development
- Nadia Hall, Office of Integration Services for Children, Ontario
- Sue Mace, Durham Infant Development
- Linda McLay, Infant Development Program, North Bay
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- Linda Rosner, Early Intervention Services of York Region
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