INFANT DEVELOPMENT PROGRAM

OF

BRITISH COLUMBIA

POLICY AND PROCEDURES MANUAL

2004

Funded by: Ministry of Children and Family Development

This is an onsite working manual and can function as an operating manual for any Infant Development Program. It outlines how to set up an Infant program, from forming the Local Advisory Committee to interview questions, to staff training and ongoing evaluation.
It is to be used in conjunction with the policy and procedure manual of the sponsoring society, as that manual has agency-specific requirements.
It meets or exceeds the requirements of accreditation by both CARF and COA.
One can access individual forms by clicking on the form in the table of contents and downloading the specific form.

INFANT DEVELOPMENT PROGRAM OF BRITISH COLUMBIA

POLICY AND PROCEDURES MANUAL

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2004 EDITION

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This is your Manual.

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SECTION I ADMINISTRATION

GLOSSARY

This Glossary provides brief definitions of terms used in the Manual.

The Ministry of Child and Family Development is the process of transferring authority to five Regional Authorities, five aboriginal authorities and an authority to govern Community Living Services. Terms marked with an asterisk * will be re-written when this transition is complete.

Accreditation

The Ministry of Child and Family Development requires that agencies running programs like the Infant Development Program be accredited. The two accreditation bodies approved for this in B.C. are Commission on Accreditation of Rehabilitation Facilities (CARF) and Council on accreditation (COA).

B.C. Association of Infant Development Consultants (BCAIDC)

A provincial association concerned with ethics and professional standards of practice for Infant Development Program Consultants.

Brochure

The Ministry for Children and Family Development provides a provincial brochure for the Infant Development Program. There is space on the brochure to have local program information added.

Caseload

Active	Home visits or other significant contact made at least once a month
Follow up	Child moves from active caseload to follow-up category when contact is made less than once a month
Monitoring	Child development is monitored by IDP through the Ages & Stages Questionnaires (ASQ) for parents (or an equivalent monitoring tool). Child is not on active caseload or receiving follow-up visits although will be moved to active if necessary.
Waitlist	Infants eligible for IDP but who are not accepted at this time because program caseload numbers are too high.

Case Review Committee (C.R.C.)

The Local Advisory Committee, or a subcommittee thereof, which acts as consultant to staff on individual cases and advises the Local Advisory Committee on issues relating to caseload and/or services. Alternatives to this committee may be met if the IDP practices Continuous Quality Assurance (QCA) process required by accreditation.

Family-Centred Care

"A collaborative relationship between families and professionals in the continual pursuit of being responsive to the priorities and choices of families" (Kennedy Institute on the Family, I.Y.C. 92(4)(3).

Individual Family Service Plan (I.F.S.P.)

An IFSP is a framework designed to enable families and professionals to work together as a team. The purpose of their combined and organized effort is to identify strengths and needs of the families and available resources, and to match these in accordance with family chosen goals. An IFSP may be a very simple plan or relatively complex depending on child and family need and individual circumstances.

Infants

Children aged birth to three years.

Infant Development Program (IDP)

Primarily home based services for infants at risk for and with developmental delay or disability and their families, as described in the Guidelines for Infant Development Programs (page 6), funded by the Ministry for Child and Family Development.

Infant Development Program Consultants (IDPC)

Infant Development Program Consultants are professionals with training in a field or fields related to early child development, hired by societies to provide all services described in the Guidelines for Infant Development Programs (page 6). To distinguish Infant Development Program Consultants from other consultants to Infant Development Programs such as physiotherapists, IDP Consultants will be referred to in some places in this Manual as Infant Development Program Staff.

Local Advisory Committee (L.A.C.)

A committee of the board of the sponsoring society which provides direction and support to the Infant Development Program staff. Parents and community professionals sit on this committee.

***Ministry for Child and Family Development (M.C.F.D.)**

The provincial government ministry responsible for funding Infant Development Programs.

Parents

Natural, foster or adoptive; the primary adult caregivers.

Provincial Advisor (P.A.)

Under the direction and with the support of the Provincial Steering Committee, the Provincial Advisor is available to advise communities re initiation, composition and operation of Infant Development Programs; to develop inservice training for staff, and to keep professional and public groups informed of developments in the field of early intervention.

Provincial Steering Committee (P.S.C.)

Appointed by the Deputy Minister for Children and Families, the Provincial Steering Committee is responsible for setting the Terms of Reference for the development and operation of Ministry for Children and Family Development funded Infant Development Programs; for setting standards for staff and service and for implementing standard evaluation procedures.

Regional Advisors (R.A.)

Five Regional Advisors appointed on a part-time basis work under the direction and with the support of the Provincial Advisor. They are available to advise staff in the clinical operation of their duties, to design regional inservice training, to advise communities on training new staff and to participate in ongoing monitoring and evaluation of programs.

***Sponsoring Society (S.S.)**

Registered, non-profit agency which employs Infant Development Program staff, and is funded by the Ministry for Child and Family Development to provide Infant Development Program services as they are described in this Manual.

0-6 initiatives:

Over the past 10 years a range of initiatives have developed which focus on infants, young children and their families. Many of these initiatives serve families with children at risk for developmental problems

The Infant Development Program should liaise closely with these initiatives to ensure that families have access to available supports and that children's development is closely monitored:

- Aboriginal Head Start (AHS) (Health Canada)
- Building Blocks - Lay Home visiting programs
- Babies Best Chance - Public Health Initiatives
- Community Action Program for Children (CAPC) (Health Canada)
- Canadian Prenatal Nutrition Program (CPNP) (Health Canada)
- Learning Sites (MCFD)
- Pregnancy outreach programs (POP)
- Parent-Child Mother Goose (P-CMG)

PRINCIPLES FOR WORKING WITH FAMILIES IN INFANT DEVELOPMENT PROGRAMS

Within a framework of family centred care the following principles are fundamental to the philosophy of the Infant Development Program in British Columbia. Staff employed in Infant Development Programs must subscribe to these principles and ensure that all Infant Development Program services conform to these principles as they relate to the infant, the family and the Infant Development Program staff.

The Family

1. Parents know their child best.
2. The family has the right to services that will assist them to live as normally as possible.
3. The parents are the chief decision makers and advocates for their child.
4. The family's needs and perception of needs will be recognized and respected.
5. The family will be encouraged to perceive the importance of their role with regard to their children and provided with tools to facilitate this role.
6. Parents will be provided with channels to assess their involvement with the program, opportunities to make policy recommendations and to monitor the overall program.

The Infant

1. The infant has a critical need for an accepting, facilitating and nurturing family.
2. The infant has the right to available and appropriate medical, educational and social services regardless of degree or multiplicity of disability.
3. The infant has the right to participate in a full range of social and community opportunities as would any infant.

Staff

1. Staff will respect the family, child and lifestyle at an individual level and in all matters relating to confidentiality.
2. Staff are aware of their role and responsibilities to the family, and are aware of the limits of their role and responsibilities.
3. Staff will support involvement of other professionals, assist in referral to appropriate resources and provide information that will be of assistance to the family.
4. Staff will have knowledge of principles of normalization and commitment to those principles.
5. Staff will be caring but professional in attitude.

INFANT DEVELOPMENT PROGRAMS IN BRITISH COLUMBIA

This manual (revised, 2004) was prepared by the Provincial Steering Committee: Infant Development Program, with input from parents and professionals involved with Infant Development Programs in British Columbia. It establishes the terms of reference for the development and operation of Infant Development Programs which are funded by the Ministry for Children and Family Development.

BACKGROUND

The first home-based Infant Development Program (IDP) in British Columbia was started by a group of parents of developmentally delayed infants and professionals involved with service provision to these children in Vancouver in 1972. With support and funding from the then Ministry for Social Services, similar programs were developed elsewhere in British Columbia. A Provincial Steering Committee was appointed by the Minister of Human Resources in 1975 to set the terms of reference for this new service as it expanded through the province. Infant Development Programs are operating in 52 communities in British Columbia serving an annual population of approximately 6,000 infants and their families. Since the program's inception, approximately 50,000 infants and their families have received regular services from IDPs.

RATIONALE

In common with similar services in the U.S.A. and elsewhere in Canada, Infant Development Programs are based on the following assumptions.

- Interventions for some children with developmental problems may be most effective if begun early in the child's life.
- Infancy is an important period of life and delays in development during that period may have long-lasting, cumulative effects on the patterns of development of a child, as well as on the patterns of interaction between the child and his/her family and community.
- The family unit is the most crucial source of learning, of emotional support and of developmental encouragement available to the child.

PHILOSOPHY

All children have the right to grow up in a safe and loving family with access to a full range of social, educational, and community experiences. It is the overall intent of the Infant Development Program to support families so that these rights may be realized. Central to this is assisting families in developing and maintaining loving relationships with their child.

The family thus becomes the primary focus of services for the Infant Development Program and the home is the centre around which programming is built. While there is no question about the necessity of good diagnostic and medical treatment, genetic counselling, and a myriad of other treatment agents, the focus of this program is to provide early support and intervention in the home through and with the family. The aims of the program are to help parents to make optimum use of available services, to enlarge their knowledge of those factors pertinent to overall growth and development of their child, and to learn skills, which will enable them to encourage the development of their child.

GUIDELINES FOR INFANT DEVELOPMENT PROGRAMS

Goal of the Program

To provide home-based services for infants at risk for developmental delay or with a diagnosed disability and their families to optimize their development and continuing participation in a full range of community activities.

SPECIFIC OBJECTIVES

1. To work with parents to enhance the overall development of the child with an emphasis on identifying individual needs.
2. To work with parents to enhance their learning opportunities about child development and community resources based on identifying individual needs.
3. To work with parents in building their relationship with child based on identifying individual needs.

POPULATION

1. The programs will serve children from birth to three years identified as at-risk for developmental delay, developmentally delayed in one or more skill areas, or with a diagnosed disability.
2. Each program will serve a specific geographic area to be determined by the sponsoring society in collaboration with the Ministry for Children and Family Development. Out of boundary families should be referred to the Regional Advisor, Infant Development Program.
3. Referrals will be received from any source and should be directed to the Infant Development Program Supervisor.

PROGRAM ADMINISTRATION

Sponsoring Society and Local Advisory Committee

Direction and support of the programs and Infant Development Program Consultants shall be in the hands of a society with assistance from an Advisory Committee, representative of the community. Representation on the committee must include parents of young children who are developmentally delayed, the Program Supervisor and a cross-section of relevant and available health, education and social service professionals. Representative(s) of local 0-6 Initiatives should be invited to participate. Staff of the Ministry for Child and Family Development act in an advisory non-voting capacity on Local Advisory Committees.

Infant Development Program Consultants

Consultants of local Infant Development Programs must have professional training in a field or fields related to early childhood development. An undergraduate degree is generally an entry level requirement. Demonstrated ability to work with infants and young children and their families as well as other professionals is essential. Organizational ability and the ability to operate independently is essential.

Provincial Steering Committee, Provincial Advisor and Regional Advisors

The Provincial Steering Committee and Provincial Advisor report to the Ministry for Child and Family Development and the Minister of State for Early Childhood Development on the operation of the programs and provide staff training, coordination and support to individual Infant Development programs.

SERVICES PROVIDED

1. Home visits will be made on a regular basis by Infant Development Program Consultants to assist the family in planning learning activities and to utilize appropriate resources in the community.

2. Parents will be given the opportunity to meet other parents to share experiences and information that may be of support to them.

3. Parents will be encouraged to attend workshops, lectures and parent meetings which will further their understanding and knowledge of child development.

4. A resource library of books and toys will be available for loan to the family.

5. The family will be referred or encouraged to seek referral to appropriate educational, social and health or disability related services.

6. The family will be informed of alternatives open to their child as he/she grows older and will be encouraged to take part in any decision-making process regarding his / her education or health services.

7. Linkages will be established with other community based early child/family initiatives to facilitate early and appropriate referral to the IDP and to ensure families have access to a range of supportive services.

8. The community will be informed of the development and progress of the program. (e.g. Annual Report)

Other services may be provided by the Infant Development Program. These services might include a group situation for infants and parents, out of boundary services, practicum placement for students, etc. The Local Advisory Committee must describe all services provided by the program.

INTRODUCTION TO OFFICE OF PROVINCIAL ADVISOR, INFANT DEVELOPMENT PROGRAM

The office of the Provincial Advisor is available to all staff working in Infant Development Programs and their employing agencies to support them in their work with infants and families. The office consists of a Provincial Steering Committee (see description page 11), the Provincial Advisor and Assistant and a part time administrative support person. Five part time (three days/ month) Regional Advisors are also employed by the office and are located in each of the 5 MCFD Regions across the Province.

This office supports the work of IDP Consultants in a variety of ways. The Provincial Steering Committee (PSC), Provincial Advisor and Regional Advisors are linked to significant academic, professional, service and family support organisations related to early intervention and child development in BC and Canada. Links extend as well to the international early intervention community. Best practice standards set in other jurisdictions are reviewed and integrated into the work done in IDPs in BC. These standards form the basis of the Policy and Procedures Manual, which is updated on a regular basis by the Provincial Office with input from IDP staff throughout BC. The Manual and other program-related information is available on the program website www.idpofbc.ca

Training opportunities have been developed at UBC in co-ordination with other universities and colleges in BC through the PSC and through an IDP and SCC Consortium. A Certificate in Infant Development is now available on line through UBC and successful completion of the certificate leads to a Diploma in Infant Development also available through UBC. Biannual inservice for all IDP Consultants is scheduled in Vancouver and training in the Gesell assessment used in the IDP is provided through this inservice. Inservice is coordinated to coincide with a biennial Early Years conference in Vancouver also sponsored in part by the IDP. Regional Inservices are held as well throughout the year and in various locations throughout BC.

The Provincial Office maintains membership in a range of disability related organisations, subscribes to over 100 disability/early intervention newsletters and professional journals and circulates relevant information to IDPs on a regular basis.

A large text and video library is available for loan to the programs and the office is responsible for maintaining the circulation of these materials efficiently throughout the province. The Provincial Office also provides staff with information on rare syndromes and specific information on early intervention strategies for a range of conditions to assist staff in their day to day work with families. Staff in the Provincial Office provide a sounding board and specific advice related to service provision to families. Families also access the office and can be connected with other families across the Province who have children with similar conditions.

Staff from the Provincial Office are available when requested to make on site visits and participate with sponsoring societies and programs in hiring and training new staff and conducting staff and program evaluations. Statistics are collected provincially, collated by the office, distributed to the programs and are available on the website. Trends identified by analysis of the statistics at local, regional and provincial levels inform practice and lead to improvements in service delivery. The website is maintained to enable staff and families easy access to program information, locations, and addresses.

The Provincial Advisor and Regional Advisors participate on a number of committees and organisations throughout BC to ensure the needs of families and young children with disability are represented. These committees include ones dealing with disability issues, government policy tables, training initiatives, data collection and accreditation.

PROVINCIAL ADVISOR - JOB DESCRIPTION

Under the direction and with the support of the Provincial Steering Committee, the Provincial Advisor is available to assist in the following areas.

- to advise local communities re initiation, composition and operation of Infant Development Programs
- to advise and support local Infant Development Program Consultants in the clinical operation of their duties
- to recruit and support the work of the Regional Advisors
- to report to the Provincial Steering Committee on the operation of local Infant Development Programs
- to design, initiate and participate in In-Service Training programs for Infant Development Program Consultants
- to keep professional and public groups who are interested and/or involved in early intervention programs informed of developments in the area of early intervention

REGIONAL ADVISOR - JOB DESCRIPTION

The Regional Advisors will work under the direction and with support of the Provincial Advisor and the Provincial Steering Committee. The Regional Advisors will be available to assist in the following areas:

- to report to the Provincial Advisor/Provincial Steering Committee on the operation of local Infant Development Programs
- to advise local communities re initiation, composition and operation of Infant Development Programs
- to advise and support local Infant Development Program staff in the clinical operation of their duties
- to design, initiate and participate in regional inservice training programs for Infant Development Program staff
- to advise communities on training new staff and to assist in the setting up of practica for new staff
- to participate in ongoing monitoring and program evaluation at the regional level

GEOGRAPHIC AREAS

The five geographic areas to be represented by Regional Advisors are:

Vancouver Coastal
Vancouver; Sheway; North Shore; Richmond; Sea to Sky, Squamish, Powell River, Sechelt

Vancouver Island
Victoria; Cowichan Valley; Duncan; Tsewultan Health Centre, Duncan; Nanaimo; Port Alberni; Nuu-Chah-Nulth Tribal Council, Port Alberni; Nuu-Chah-Nulth Tribal Council, Tofino; Oceanside, Qualicum Beach; Comox Valley, Courtenay; Campbell River; Nuu-Chah-Nulth Tribal Council, Gold River; Namgis Band, Alert Bay; Quatsino Indian Band, Coal Harbour; North Island, Port Hardy; Gwa'Sala-'Nakwaxda'xw Family Services, Port Hardy; Klemtu Health Clinic, Port Hardy; Kwakiutl Indian Band, Port Hardy; Sunshine Coast

Fraser
Maple Ridge; Langley / Aldergrove; Burnaby / New Westminster; Delta; Coquitlam; Ridge Meadows; Surrey / White Rock; Upper Frazer Valley

Interior
Princeton; Nicola Valley, Merritt; Nzen'man' Child and Family, Lytton; Lillooet; Kamloops; South Caribou, 100 Mile House; Williams Lake; Bella Coola; Salmon Arm; Splatsin, Enderby; Vernon; Kelowna; South Okanagan, Penticton / Oliver; Lower Similkameen Indian Band, Keremeos; Boundary, Grand Forks; West Kootenay, Castlegar; East Kootenay, Cranbrook / Invermere; Golden; Revelstoke

North
Quesnel; Fort Nelson; Fort St. John; South Peace, Dawson Creek; Robson Valley; Mackenzie; Prince George; Vanderhoof; Tl'azt'en Nation, Tachie; Burns Lake; Smithers; Terrace; Kitimat; Prince Rupert; Queen Charlotte Islands

PROVINCIAL STEERING COMMITTEE

TERMS OF REFERENCE

1. To provide direction and support to the Provincial Advisor

2. To recommend general Terms of Reference for the development and operation of Infant Development Programs

3. To review, revise, and maintain the Policy and Procedures Manual, which covers both the development and operation of Infant Development Programs in B.C.

4. To screen proposals for new programs and to make recommendations to the Ministry for Children and Family Development

5. To assist in the development of appropriate systems of program evaluation and longitudinal post-program follow-up for use of local programs

6. To assist programs in the accreditation process and to support recommendations based on accreditation that are consistent with best practice.

7. To facilitate communication among the Infant Development Programs, Societies, Executive Directors, Local Advisory Committees and staff, as well as other agencies and societies involved with special needs in infancy and childhood

8. To facilitate communication and community capacity building with all other 0-6 initiatives.

9. To develop training opportunities for Infant Development staff, and to assist educational institutions to develop training programs, e.g. Summer Institute, UBC; Certificate/Diploma Program, UBC; Knowledge Network, UBC; School of Child Care, University of Victoria IDP/SCC consortium

10. To provide advice and to review information, e.g. pamphlets and reports on the Infant Development Programs prepared by the Ministry for Children and Family Development

11. To provide recommendations to the Ministry for Children and Family Development regarding other services that relate to Infant Development Programs, e.g. Supported Child Care

12. To review standards of service and to act as an advisory body to local Infant Development Programs and their Advisory Committees

13. To review trends in diagnostic classification and in referral to the programs and to make recommendation for criteria for referral of infants to Infant Development Programs

14. To screen all requests for research involving Infant Development Program populations and to facilitate ongoing research in child and family development.

These Terms of Reference are further expanded on the following pages.

NOTES ON THE TERMS OF REFERENCE

1. **To provide direction and support to the Provincial Advisor**

   At the local level, staff report to a Local Advisory Committee comprised of parents and professionals in fields relating to infant development. The same model is used provincially. Qualified advisors representing B.C. Children's Hospital, universities and other agencies and parents provide access to information and resources that staff working in isolation would have difficulty accessing.

2. **To recommend general Terms of Reference for the development and operation of Infant Development Programs**

   The terms of reference for the development and operation of programs must reflect current research. Knowledge in the field of early intervention and delayed development is rapidly expanding and findings must be readily available to practitioners.

3. **To review, revise, and maintain the Policy and Procedures Manual, which covers both the development and operation of Infant Development Programs in B.C.**

   The Infant Development Program Policy and Procedures Manual provides direction to local communities in the operation of an Infant Development Program. This manual covers issues relating to administration, staff training, record keeping, accountability procedures, resource materials including books, toys, and equipment, and guidelines for home visits and other services provided by the program. There is need for regular updating to reflect current trends in the field as well as new resources.

4. **To screen proposals for new programs and to make recommendations to the Ministry for Children and Family Development**

   The committee reviews proposals for new programs and has, on a number of occasions, recommended changes to proposals in areas such as population served, makeup of local advisory committees or services provided by the program. It is felt that assistance early on in the development of a program may prevent future problems.

5. **To assist in the development of appropriate systems of program evaluation and longitudinal post program follow-up for use of local programs**

   The committee has investigated a number of systems of evaluation over the years. At the request of Dr. David Mitchell from New Zealand, the committee reviewed his Scale for Evaluation of Early Intervention Programs and made several recommendations with regard to criteria, which were subsequently incorporated into that draft. This evaluation was field tested with eight Infant Development programs in British Columbia in September 1987 at the recommendation of the Provincial Steering Committee. It is recommended that all Infant Development Programs be evaluated every five years with this tool or one similar. It is anticipated that in future the Provincial Steering Committee and the Ministry of Education will investigate the possibility of longitudinal monitoring of children graduating from Infant Development Programs, as this was identified as a need by the Mitchell Evaluation.

6. **To assist programs in the accreditation process and to support recommendations based on accreditation that are consistent with best practice. This manual is written to comply completely with both CARF and COA. Staff are available to work with programs to ensure compliance with accreditation standards.**

7. **To facilitate communication among the Infant Development Programs, Sponsoring Societies, Executive Directors, Local Advisory Committees and staff, as well as other agencies and societies involved with special needs in infancy and childhood.**

   To facilitate communication, the Provincial Steering Committee collects statistics and circulates compiled statistics on the program. It has also sponsored a workshop for Executive Directors and Local Advisory Committee Chairpersons of Infant Programs and anticipates holding subsequent workshops in the future. The committee has also prepared materials relating to specific disabilities for inclusion in the Ministry of Health, Public Health Policy Manual

8. **To facilitate communication and community capacity building with all other 0-6 initiatives.**

   Many communities now offer a range of initiatives to support infants and young children and their families. IDPs have much to offer these initiatives and conversely these initiatives can have a positive impact on child and family life. The Provincial Steering Committee will promote collaboration of these initiatives at the local, regional, provincial and federal level.

9. **To develop training opportunities for Infant Development staff, and to assist educational institutions to develop training programs, e.g. Provincial IDP Inservice, Summer Institute, UBC; Diploma Program, UBC; Knowledge Network, UBC; School of Child Care, University of Victoria and IDP/SCC Consortium**

   The Provincial Steering Committee recommends topics and resource people for presentation at the two provincial inservices held in Vancouver annually. The Training Committee, a sub-committee of the PSC, has met with representatives from the Faculty of Education, Special Education Department to develop the Certificate/Diploma in Infant Development, the first such diploma in Canada. The committee also participates in decisions regarding topics and presenters for the Institute on Infant Development held at UBC annually for two weeks in July. The PSC meets, as well, with Infant Development Program staff to discuss training issues among other items. The IDP/SCC consortium meets regularly to develop accessible courses and promotes partnerships across the sectors.

10. **To provide advice and to review information, e.g. pamphlets and reports, on the Infant Development Programs prepared by the Ministry for Children and Family Development**

    The Provincial Steering Committee recommended substantial revisions for the IDP brochure, which were accepted by the Ministry for Children and Family Development.

11. **To provide recommendations to the Ministry for Children and Family Development regarding other services that relate to Infant Development Programs, e.g. Supported Child Care.** The PSC has made recommendations to the Ministry for Children and Family Development in areas relating to foster care and preschool, and the issue of support to parents who have mental disabilities.

12. To review standards of service and to act as an advisory body to local Infant Development Programs and their Advisory Committees

Accreditation was undertaken as a review of standards of service. The committee acts as an advisory body to local programs and has developed surveys of parent satisfaction for the use of programs, and an evaluation of staff. It also handles a number of individual requests for information.

13. To review trends in diagnostic classification and in referral to the programs and to make recommendations for criteria for referral of infants to Infant Development Programs

The sub-committee on referrals to Infant Development Programs reviews referral information and advises on changes in populations referred to Infant Programs. Improvements in neonatal intensive care nurseries have resulted in increased referrals of children at risk due to prematurity and medical complications associated with pre-maturity.

14. To screen all requests for research involving Infant Development Program populations and to facilitate ongoing research in child and family development.

Some members of the PSC are involved in ethics and research committees in other settings and review requests for research involving Infant Development Program populations. Decisions to recommend that research be permitted are based on the degree of direct benefit to the population served and the assurance by the researcher that findings will be reported back to the Infant Program and to the families who participated in the study. The Human Early Learning Partnership (H.E.L.P) and the Consortium for Health, Intervention, Learning and Development (C.H.I.L.D.) at UBC are actively engaged in child and family research initiatives that will impact on individuals and communities connected to IDPs. The PSC will provide support to programs that participate in these initiatives.

LOCAL ADVISORY COMMITTEE

TERMS OF REFERENCE

The purpose of the Local Advisory Committee is to concern itself with the development and continuity of programs and services for infants with developmental concerns and their families in the geographical area covered by the Infant Development Program.

1. To be aware of the standards set by the Provincial Steering Committee and the Ministry for Children and Family Development and to assist the Infant Development Program in meeting these standards

2. To provide consultation to the society in the hiring and ongoing monitoring of the Infant Development Program staff

3. To assist the staff in reaching the goals of the Infant Development Program

4. To encourage the development of quality programs for infants and their families, to foster close collaboration with existing 0-6 programs and to develop proposals to overcome gaps or inadequacies in service

5. To encourage parent-to-parent support

6. To foster good relationships between parents receiving service and professionals

7. To facilitate the sharing of information in the area of early intervention

8. To act as a direct communication vehicle for staff to the Board of Directors of the sponsoring society

9. To assist staff in monitoring and evaluating the IDP which may include parent and professional surveys, accreditation, the Mitchell Evaluation and other evaluations determined by the sponsoring society

10. To assist with recruitment of community members and parents reflective of community to the Local Advisory Committee, and to articulate the importance and role of the Local Advisory Committee. basis

11. To ensure that committee meetings are held on a regular basis

These terms of reference are further expanded in the following pages.

NOTES ON THE TERMS OF REFERENCE FOR THE LOCAL ADVISORY COMMITTEE

1. **To be aware of the standards set by the Provincial Steering Committee and the Ministry for Children and Family Development, and to assist the Infant Development Program in meeting these standards**

   To further this, members of the Local Advisory Committee should familiarize themselves with the Societal Agreement set by Ministry for Children and Family Development, the IDP Manual and other related materials distributed to them by the Ministry for Children and Family Development and the Provincial Advisor and/or Regional Advisors, and seek clarification from the Ministry for Children and Family Development and Provincial Advisor and/or Regional Advisors if there are problems with interpretation.

2. **To provide consultation to the society in the hiring and ongoing monitoring of the Infant Development Program Consultants**

   The Local Advisory Committee must have a working knowledge of the written procedures concerning the selection, hiring and monitoring of staff for Infant Development Programs. Hiring must also conform to procedures established by the society.

3. **To assist Infant Development Program Consultants in reaching the goals of the Infant Development Program**

   The Local Advisory Committee should work with the IDP Consultants to establish priorities related to meeting the goals of the program and to ensure the services provided meet the Guidelines set by the Provincial Steering Committee as outlined in the Agreement with Ministry for Children and Family Development and this Manual. Examples of areas in which the Local Advisory Committee may need to assist:

   Sponsorship - The Local Advisory Committee must ensure that the Society is kept up-to-date on the development of the program (e.g. program changes, caseload variance, etc.). As the membership of the Local Advisory Committee includes a representative of the Board of the Society, communication should be facilitated.

   Administrative - Adequate administrative and support services, such as clerical, are essential to the program. The Local Advisory Committee may need to review frequently the amount of support needed and make recommendations to the Society for additional secretarial time, telephone answering services, etc.

   Caseload – (Recommended caseload 15-25 per consultant depending on population and geography) There will be regional differences and it is up to LAC in consultation with the Regional or Provincial Advisor to determine appropriate practice

   When the caseload increases to a size that cannot be effectively managed by existing staff, and funds to hire additional staff are not forthcoming, the Local Advisory Committee and staff must make recommendations regarding priorities as to the services provided by the program. Specific client-related issues of caseload should be referred to the Case Review Committee. Questions that should be asked include:

a) Are there areas of work in which the program supervisor could transfer more responsibilities to the society, Local Advisory Committee or volunteers? e.g. clerical, parent meetings, parent and tot groups, public awareness, etc.

b) Which services provided by staff could be reduced or discontinued? e.g. practicum students, education of professionals in the community, consultations to other agencies, etc.

c) Can the existing caseload be reduced? e.g. out-of-boundary referrals; follow-up or consultation on at-risk population; less time with two to three year olds; waiting list for new referrals.

d) Waitlist information

4. To encourage the development of quality programs for infants and their families, to foster close collaboration with existing 0-6 programs and to develop proposals to overcome gaps or inadequacies in services

The Infant Development Program is only one of many services or programs that should be available to families with children 0-6 in a community. The Local Advisory Committee should support existing programs and encourage the development of additional resources where need is demonstrated. The Local Advisory Committee could look at the community and determine what is available, e.g. Paediatric services including regular assessment and diagnostic work-ups should be available through the health unit, hospital or other agency; education for parents in the area of child development, management, etc. should be available in a number of ways: lectures, workshops, information centres, etc. via public health, community colleges or other agencies.

If gaps or inadequacies in services are identified, the Local Advisory Committee and society should work with other concerned agencies to bring about improvements. e.g. to ensure that developmental screening is available to children participating in 0-6 initiatives.

5. To promote parent-to-parent support

With co-ordination from staff, parents on the Local Advisory Committee and/or parents receiving service may make themselves available to visit and offer support to parents in the birth hospital or at home. Continued support can take place through home visits, telephone contact or parent meetings. Families will also benefit if they have access to the Family Support Institute and their network of Resource Families.

6. To foster good relationships between parents receiving service and professionals

By design, the Local Advisory Committee with parent and professional representation, should foster good relations. The Local Advisory Committee could introduce themselves via a letter sent to all families when accepted into the IDP (see Sample Letter page 21). In addition, the committee could encourage both parents and professionals to meet through workshops, etc. to discuss mutual concerns such as:

a) the need for parent participation in all decisions regarding their child's education or health services.

b) opportunities for parents to learn the roles and responsibilities of the various professionals they deal with so that the parent has reasonable expectations from the professional.

c) the needs of parents to have control over the amount, type and intensity of professional services provided.

d) the need for professionals in a community to have good feedback as to how well they are meeting the needs of a family.

e) assistance to parents in locating appropriate counselling services.

7. To facilitate the sharing of information in the area of early intervention

The Local Advisory Committee should examine ways to keep their community informed about the Infant Development Program to ensure early and appropriate referrals. As well they should develop methods to ensure ongoing education of the public and professionals about the importance of early years and early intervention in delayed development. Some examples of areas in which this could be fostered include:

a) The program brochure with the up-to-date address and telephone number of the program should be available in Public Health Units and other community agencies. Notices of the program should be posted in places that families visit: laundromats, food banks, etc. Letters describing the program and brochures should be mailed to paediatricians and general practitioners on a regular basis.

b) Packages of information on Down Syndrome and a general package on delay should be available for parents in a birth hospital or Paediatric ward of the hospital. All senior hospital staff should have regular reminders (rounds once/year), about the Infant Development Program and be encouraged to distribute packages or information to families they feel would benefit from this service. Maternity wards and intensive care nurseries should be reflecting current knowledge and research regarding beneficial hospital experiences for parents of infants diagnosed as disabled.

c) Parents on the Local Advisory Committee and in the program should be encouraged to undertake speaking engagements or interviews regarding the Infant Development Program to describe their own experiences with the program.

d) Packages of information on the program should be available on request to interested persons.

e) Professionals on the Local Advisory Committee should keep colleagues up-to-date in this area.

f) Pre-natal and well-baby clinics should be encouraged to include in their training programs information on the significance of early intervention.

g) The local library could be requested to supplement their resources with recommended purchases. Out of date materials should be screened.

h) Some community college and university courses should include references to early intervention. Courses relating to infant development and early intervention can be established through community colleges.

i) The Family Life curriculum in local high schools should have sections relating to early intervention.

j) Local TV, radio, newspapers, should cover areas of general information.

8. To act as a direct communication vehicle for the staff to the board of directors of the society

The Local Advisory Committee representative of the board of the society and/or staff must report regularly to the board on the development of the Infant Development Program and the work of the Local Advisory Committee.

9. To assist staff in monitoring and evaluating the IDP which may include parent and professional surveys. accreditation, the Mitchell Evaluation, and other evaluations determined by the sponsoring society.

10. To assist with recruitment of community members and parents reflective of community to the Local Advisory Committee, and to articulate the importance and role of the Local Advisory Committee.

The local advisory should be representing the IDP to community partners, families and promoting family and community participation in the IDP. It is important to work in partnership so that IDP maintains a high community profile and involvement in the program in an advisory capacity is strong from many sectors of the community, i.e. a cross section range of family input, business, municipal government, etc.

11. To ensure that committee meetings are held on a regular basis

The Local Advisory Committee should meet, at a minimum, every 6 - 8 weeks in the early years of program and community development. Some Local Advisory Committees may choose to meet less frequently unless staff changes or other program issues necessitate more regular monitoring of the program and its services. For well established programs, meetings should be held at a minimum of three times a year.

LOCAL ADVISORY COMMITTEE MEETINGS AND RECORDING METHODS

A. Meetings

Meetings should be held every 1 to 2 months for new programs, quarterly for established programs. Some Committees feel that a standing time and place for meetings is the most efficient method. This enables people to plan well ahead.

B. Membership

Parents and professionals must be represented as described in the Guidelines. Terms of office for membership should be discussed.

Chair: One chairperson or co-chairpersons are preferable to a rotating chair. Terms of office for the chair should be discussed.

C. Minutes

Minutes should be kept by a recording secretary, although some committees rotate minute taking through the membership. Minutes are an extremely useful source of information and can:

1. comprise the board representative's monthly report to the board of the society;
2. be a basis for an annual report to the society;
3. be distributed to new committee members to bring them up-to-date on the Infant Development Program;
4. present a picture of work accomplished and work left to be done;
5. assist the committee to set priorities for the future.

Minutes should be mailed out to all committee members as soon as possible following the meeting. This enables corrections to be made while the meeting is fresh in members' minds. This also serves as a reminder to individual members if work has been allotted to them. The date of the next meeting should be set at the meeting and included in the minutes.

D. Agenda

The agenda should be sent out two weeks in advance of the next meeting so that committee members have three reminders of the date:

- date set at meeting
- date from the minutes
- date on agenda

Typically the agenda is set out as follows:

1. members present
2. minutes of the last meeting
3. business arising from the minutes
4. report from staff
5. new business
6. date of the next meeting

This also gives order and consistency to the minutes.

SAMPLE LETTER LOCAL ADVISORY COMMITTEE TO FAMILIES

Dear Parent:

The Advisory Committee wishes to welcome you and your family to the _____ Infant Development Program.

You might be interested in knowing the make up and function of the committee. There are approximately twelve members, representing parents of infants on the program, parents who have received the service, volunteers from the community, representatives from health and social service professionals, including those from the Ministry for Children and Families, our funding source.

The mandate of the Advisory Committee is to: oversee the program by encouraging staff and board members to follow the Infant Development Program Provincial Manual; have a representative on the hiring committee for new Infant Development Consultants; provide moral support for parents; promote early intervention and quality programs for children; support and foster public awareness; ensure adequate funding for the program and maintain a Case Review Subcommittee.

The Case Review Committee briefly reviews new referrals and children on the caseload. This procedure ensures appropriate referrals and services for families on the program. As confidentiality is paramount, no parents are on this committee. Members of the Case Review Committee include an Infant Development Consultant, Paediatrician, Public Health Nurse, Social Worker, and, occasionally, other professionals. A report in the form of statistics is given to the Advisory Committee. When a team meeting is warranted, parents attend and usually decide which of the professionals involved in their family's care will attend.

The Advisory Committee works with other Regional or Provincial bodies and it would be our pleasure to forward more information to you.

It is the-hope of the Committee to serve you well during your time in the program.

Yours sincerely,

Jane Doe, Chairperson, Advisory Committee
123 Main Street, Vancouver, B.C.
Phone: 604-555-1234

STARTING AN INFANT DEVELOPMENT PROGRAM

This section describes the route a community should take to start an Infant Development Program. Typically, parents and professionals in a community gather to discuss the need for this service. At this time a committee of parents and professionals is formed to work towards the establishment of an Infant Development Program. This committee is referred to throughout this document as the Local Advisory Committee.

THE BRIEF

The Local Advisory Committee prepares a brief to be presented to the board of the sponsoring society for approval and forwarding to the Regional Manager, Ministry for Children and Family Development and the Provincial Steering Committee, Infant Development Program. The following information must be included in this brief.

OUTLINE OF INFANT DEVELOPMENT PROGRAM BRIEF

1) Society -
   - Title:
   - Address:
   - Executive Director:
   - Chairman of the Board:
   - Brief description of services presently provided by the society.
2) Local Advisory Committee -
   - Names:
   - Positions:
   - Addresses:
3) Geographic area to be served
4) Identified caseload
5) Location of Infant Development Program office
6) Services to be provided by the Infant Development Program
7) Support services available to the Infant Development Program
8) Brief description of existing programs for infants and preschoolers in the area
9) Budget
10) Appendix - Letters of support from representatives of the following groups:
    - Medical community
    - Public Health
    - Disability groups, etc.
    - Parents who will be receiving services

NOTES ON THE OUTLINE OF THE BRIEF

A. Society

To receive government funds, the sponsoring society must be registered under the Societies Act. The society must have commitment to the philosophy, goals and guidelines of the Infant Development Program, as described in this Manual.

B. Local Advisory Committee

Membership must include:

a) member(s) or servant(s) of the board of the society.
b) parents of infants or young children who have received services from an IDP or will receive service (e.g. when program starts).
c) representative(s) from Public Health.
d) representative(s) from the Ministry for Children and Family Development (non-voting).
e) Infant Development Program Consultant - when hired (non-voting).
f) it is highly recommended that a physician be a member on the committee.
g) cross-section of other relevant health, education and social service professionals (eg. local 0-6 initiatives).

The Local Advisory Committee plays an advisory role in developing and operating local programs. It is understood that its role may vary to some extent from one community to another in accordance with the organization and structure of the society. It is recommended that the board of the society and Local Advisory Committee meet to negotiate and come to agreement on the Terms of Reference for the Local Advisory Committee.

C. Geographic Area to be Served

The Local Advisory Committee should look at several factors when deciding the area Infant Development Program staff can effectively cover in providing service. The representative from Public Health may be of assistance here as Public Health nurses have established parameters for home service. Factors that should be discussed may include:

a) the population, how it is clustered and the birth rate
b) analysis of social determinants of health in relationship to infants / young children
c) the climate, geography, and winter travel problems.
d) existing Ministry for Children and Family Development, Public Health and School District boundaries.
e) proximity of other Infant Development Programs.
f) availability of other 0-6 initiatives and programs
g) location of the Infant Development Program office in relation to the above.

D. Identified Caseload

For the purpose of this brief and for the initial caseload for the staff person, it is necessary that the medical community and Public Health provide the Local Advisory Committee with a list of infants aged birth to three years identified as at risk and/or developmentally delayed living within the geographic boundaries of the proposed program. For purposes of confidentiality, names and addresses must not be distributed to the committee. However, the information requested from Public Health and the medical community should include the following for each child:

a) generally where he/she lives
b) age in months
c) cause of delay (if known)
d) description (brief) of delay, how assessed and by whom *(e.g. Ages and Stages Questionnaire-Public Health Nurse)*

E. Location of Infant Development Program Office

The choice of office location of an Infant Development Program is an important decision. Consideration should be given to an established generic community agency which provides a broad range of services to children and families and which may also be a referral source. (e.g. Public Health unit). A location central to the population served, accessible and close to public transportation is highly recommended.

F. Services to be Provided by the Infant Development Program

These services must include those outlined in the Guidelines for Infant Development Programs in this Manual.

G. Support Services Available to the Infant Development Program

The Local Advisory Committee should list those agencies and/or individuals in a position in the community to provide support to infants, their families and the Infant Development Program. Typically, these would include resources such as Paediatric diagnostic and assessment services, physiotherapy, speech therapy, supported child care consultants, counselling services, etc.

H. Brief Description of Existing Programs for Infants and Preschoolers in the Area

These might include parent and tot groups, family resource centres, Building Blocks programs, daycare, pre-schools, etc. This is to ensure that the Infant Development Program will supplement, rather than duplicate, existing services. It will also provide the staff person with relevant information about the community.

I. Budget

This should be drafted in consultation with the local Ministry for Children and Family Development, the Provincial Advisor and/or Regional Advisor and be included in the brief. A sample budget covering aspects of program operation is included in this Manual.

J. Appendix

Letters of support should be requested from local individuals or agencies who are in a position to recognize the need for such a service and/or to refer infants to the program when it commences. Letters may be requested from parents, physicians, public health nurses, pre-school and Supported Child Care staff, therapists, etc.

PROGRAM EVALUATION

A. MONITORING

It is the responsibility of staff, the Local Advisory Committee and the Sponsoring Society to monitor their Infant Development Program. This is an ongoing process. The Provincial Advisor and the Regional Advisors are available to assist in this process. It is recognized that ongoing monitoring of the program encompasses a wide variety of means including active participation of the Local Advisory Committee in providing direction to the program. The following are tools that have been developed to look at different aspects of the program and are found in this manual.

Annual Review of Staff
This review (page 78) is designed to assist Infant Development Program staff to improve his/her service to families. It should be administered first during the probationary period and annually thereafter.

Parent Survey 1 (page 28) **Families Receiving Service**
These forms, or forms similar to them, should be distributed to families in the Infant Development Program semi-annually by the Local Advisory Committee or Program staff.

Parent Survey 2 (page 31) **When Child and Family Leave Program**

These forms, or forms similar to them, should be distributed to the family when the child leaves the Infant Development Program.

Professional Attitudes and Practices (page 186)
This form should be used by staff to monitor the relationships they have with families.

Questionnaire for Community Professionals (page 33)
This form or one similar should be distributed to community professionals in the areas served by the Infant Development Program. This should be done annually by the Local Advisory Committee. This may be done less frequently (i.e. bi-annually) when programs have been in operation with no staff changes for a lengthy period.

B. ACCREDITATION

Accreditation is the process that MCFD will use to ensure agencies delivering MCFD funded services meet certain standards. MCFD has approved two accreditation councils and the agency may choose to accredited by one or the other. Compliance with this manual (revised 2003) will meet or exceed all standards set by CARF or COA.

C. EVALUATION

The Scale for Evaluating Early Intervention Programs was developed by Dr. David Mitchell and was field tested with eight Infant Development Programs in BC in 1987. It is envisioned that regular administration of this Scale will become standard procedure for all Infant Development Programs in the future. The purpose of this scale is to assist in the development of high quality early intervention programs for infants with developmental disabilities and their families. The scale is primarily used as a formative evaluation procedure which enables staff, parents, professionals, and administrators to plan future directions for their program.

This evaluation requires the participation of Infant Development Program staff, parents, Local Advisory

committee and the Sponsoring Society as well as one or two external evaluators. Preliminary reading and assembly of certain program materials is required. The on-site evaluation takes 1½ working days. A written report based on the evaluation findings is available to all participants within two months of the evaluation. Program goals, both short term and long term, can be established by the Infant Development Program based on the evaluation and the report. For more information on this evaluation, please contact the Provincial or Regional Advisors.

APPENDIX I-A PARENT SURVEY 1 PARENTS RECEIVING SERVICE

SAMPLE LETTER

Agency
Address
Date

Mr. And Mrs. B.
92 Avenue
Ft. St John, B.C.

Dear Mr. And Mrs. B.

As your child, _____ has been on the Ft. St. John Infant Development Program for six months we ask you to complete our parent survey.

This survey was developed by parents and professionals involved in the Infant Development Program serving children from birth to three years. Surveys such as this enable parents and professionals to review services, to make changes if necessary and to reinforce staff for doing a good job. For parents it allows regular opportunities to express satisfaction or concerns about a program. This information can help us improve our service to you and/or to other families.

The form is designed to be filled in by one parent. Mothers and fathers sometimes have different experiences with the program. If you wish, please ask for two forms from your Infant Consultant.

Thank you for taking the time to complete this survey.

Yours truly,

Consultant, Infant Development Program or

Member, Local Advisory Board

PARENT SURVEY 1 PARENTS RECEIVING SERVICE

1. The Infant Development Consultant (IDP) supported my family in developing and maintaining a positive relationship with my child.

1	2	3
No	Some	Great Deal

2. My knowledge of my child's development as a result of participating in the IDP:

1	2	3
Remained the same	Grew some from the information received	Grew a great deal above what I already knew

3. My awareness of other services in my community for my child and family as a result of participating in the IDP:

1	2	3
Remained the same	Grew some from the information received	Grew a great deal above what I already knew

4. My ability to help my child learn:

1	2	3
Did not improve	Improved some	Improved a great deal

5. The quality of services provided by the IDP to my family was:

1	2	3	4
Poor	Fair	Good	Excellent

6. The skills of the IDP Consultant were:

1	2	3	4
Poor	Fair	Good	Excellent

7. The Consultant was sensitive to the needs and wishes of my family:

1	2	3
No	Some	A great deal

8. To what extent did you feel you had control over the help you received from staff and / or the Program. Please indicate the amount of control you felt you had:

0	1	2	3	4	5	6	7	8	9	10
No control										A great deal of control

9. My privacy was respected by the agency / program:

1	2	3
No	Some	A great deal

1. What I liked best about the IDP? _____

   _____

   _____

2. What could we improve? _____

   _____

   _____

3. How long in IDP? Check one:

   - ❑ 0 – 6 months
   - ❑ 6 months – one year
   - ❑ One – two years
   - ❑ Two – three years

4. What I liked the least about the IDP? _____

   _____

   _____

5. Additional Comments: _____

   _____

   _____

6. Are you interested in learning more about the Local Advisory Committee (LAC) for the IDP?

   □ Yes □ No

   Consultant's Name: _____

   Optional Information: _____

   _____

   Your Name: _____

   Your Child's Name and Date of Birth: _____

APPENDIX I-B PARENT SURVEY 2 WHEN CHILD AND FAMILY LEAVE PROGRAM

SAMPLE LETTER FOR PARENT SURVEY 2

Agency
Address
Date

Mr. And Mrs. B.
92 Avenue
Ft. St John, B.C.

Dear Mr. And Mrs. B.

As your child, _____ recently left the Ft. St. John Infant Development Program, we ask you to complete our parent survey.

This survey was developed by parents and professionals involved in the Infant Development Program serving children from birth to three years. Surveys such as this enable parents and professionals to review services, to make changes if necessary and to reinforce staff for doing a good job. For parents it allows regular opportunities to express satisfaction or concerns about a program. This information can help us improve our service to you and/or to other families.

The form is designed to be filled in by one parent. Mothers and fathers sometimes have different experiences with the program. If you wish, please ask for two forms from your Infant Consultant.

Thank you for taking the time to complete this survey.

Yours truly,

Consultant, Infant Development Program or

Member, Local Advisory Board

PARENT SURVEY 2
WHEN CHILD AND FAMILY LEAVE PROGRAM

1. The Infant Development Consultant (IDP) supported my family in developing and maintaining a positive relationship with my child.

1	2	3
No	Some	Great Deal

2. My knowledge of my child's development as a result of participating in the IDP:

1	2	3
Remained the same	Grew some from the Information received	Grew a great deal above what I already knew

3. My awareness of other services in my community for my child and family as a result of participating in the IDP:

1	2	3
Remained the same	Grew some from the Information received	Grew a great deal above what I already knew

4. My ability to help my child learn:

1	2	3
Did not improve	Improved some	Improved a great deal

5. The quality of services provided by the IDP to my family was:

1	2	3	4
Poor	Fair	Good	Excellent

6. The skills of the IDP Consultant were:

1	2	3	4
Poor	Fair	Good	Excellent

7. The Consultant was sensitive to the needs and wishes of my family:

1	2	3
No	Some	A great deal

8. To what extent did you feel you had control over the help you received from staff and / or the Program. Please indicate the amount of control you felt you had:

0	1	2	3	4	5	6	7	8	9	10
No Control								A great deal of control		

9. My privacy was respected by the agency / program:

1	2	3
No	Some	A great deal

10. What I liked best about the IDP? _____

_____

_____

11. What could we improve? _____

_____

_____

12. How long in IDP? Check one:
    - ❑ 0 – 6 months
    - ❑ 6 months – one year
    - ❑ One – two years
    - ❑ Two – three years

13. What I liked the least about the IDP? _____

_____

_____

14. Additional Comments: _____

_____

_____

15. Are you interested in learning more about the Local Advisory Committee (LAC) for the IDP?
    □ Yes □ No

16. Are you interested in participation on the LAC for the I.D.P.?

    □ Yes □ No

Consultant's Name: _____

Optional Information: _____

_____

Your Name: _____

Your Child's Name _____

Date of Birth: _____

APPENDIX I-C QUESTIONNAIRE FOR COMMUNITY PROFESSIONALS

The _____ Infant Development Program is administered by

_____

It is a home-based program, providing assessment and follow-up of children from birth to three years of age who are developmentally delayed in any area or who are at significant risk for delays.

Service is provided to the communities of _____

_____

1. Your profession: _____
2. Are you aware of the services of the Infant Development Program (IDP)?

   Yes _____ No _____ (If no, proceed to question #11)
3. Do you have families who receive(d) services from the IDP?

   Yes _____ No _____ (If no, proceed to question #11)
4. Have you made referrals to the IDP in the past year?

   Yes _____ # of referrals _____ No _____

KEY: VD = Very Dissatisfied D = Dissatisfied S = Satisfied VS = Very Satisfied Please use space provided after each question for comments.	**VD**	**D**	**S**	**VS**
5. Do you feel that the Program responds promptly to your referrals?				
6. Do you feel that the Program adequately communicates the progress of the child, e.g., through regular developmental reports?				
7. Do you feel that the Program provides competent services to families?				
8. Do you feel that the Program brings about positive developmental changes in the children that it serves?				

KEY: VD = Very Dissatisfied D = Dissatisfied S = Satisfied VS = Very Satisfied Please use space provided after each question for comments.	**VD**	**D**	**S**	**VS**
9. Do you feel the Program contributes in a positive way to parents' awareness of: a) stages of their child's development? b) community resources available? c) their role as advocates for their child?				
10. Do you feel the Program contributes in a positive way to the community's awareness of the needs of developmentally delayed infants and children?				

11. Would you like an information package about the Infant Development Program?

Yes _____ No _____

If yes: (please print)

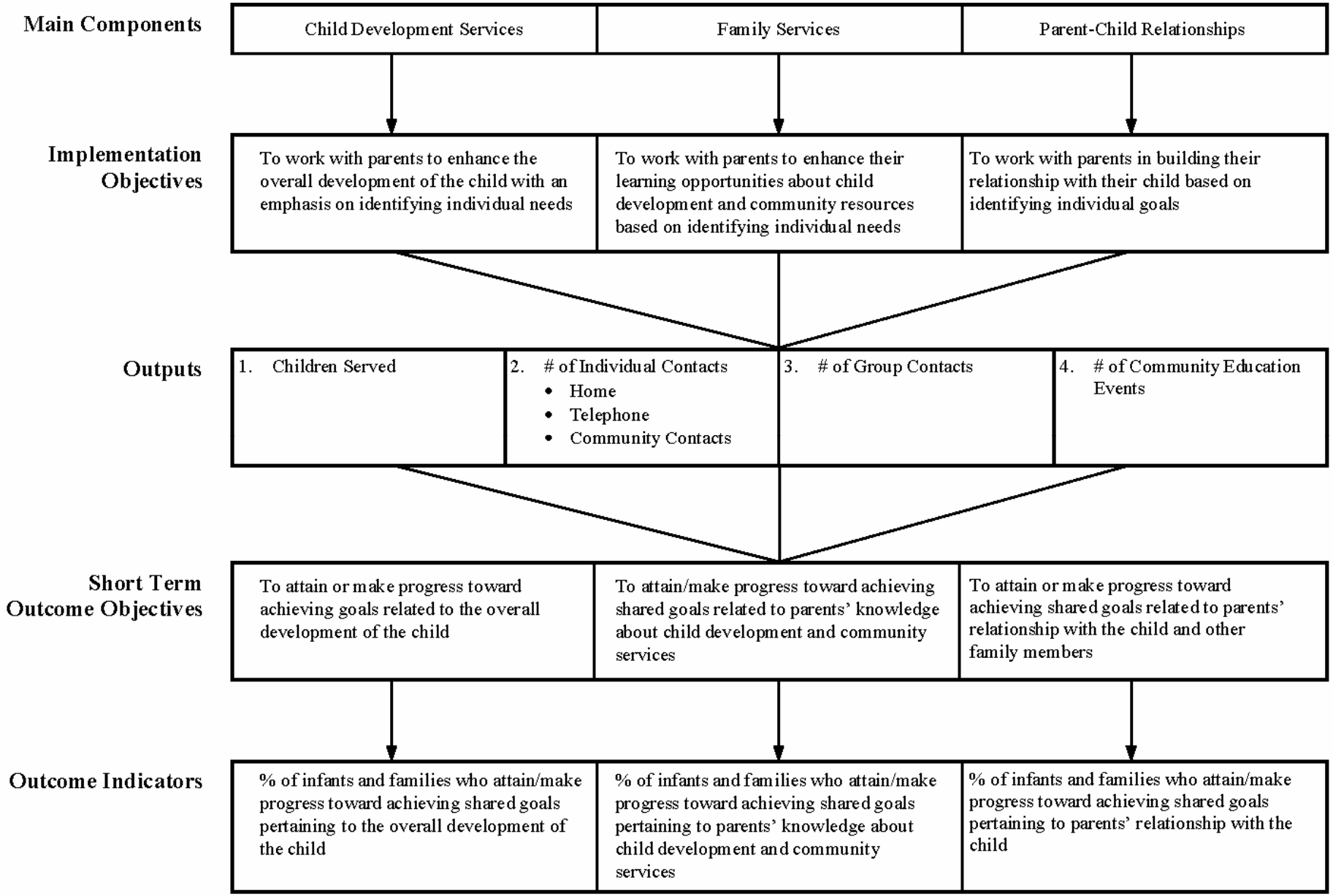
Name: _____

Address: _____

Telephone: _____

We would appreciate your comments and concerns that may help us improve our services:

LOGIC MODEL FOR INFANT DEVELOPMENT PROGRAM OF BC



EXECUTIVE SUMMARY

Using the Program Logic Model and information from Parent and Professional Surveys, the Consultant can create a picture of what the Infant Development Program has accomplished over the past year. The Summary can be used to both highlight successes and set goals. The following sample summary is the work of Jane Scott, Supervisor, Surrey / White Rock Infant Development Program

SAMPLE OF AN EXECUTIVE SUMMARY

The family is the primary focus of services for the Infant Development Program and the home is the centre around which programming is built. The aims of the program are to help parents to make optimum use of available services, to enlarge their knowledge of those factors pertinent to the overall growth and development of their child, and to learn skills which will enable them to encourage the development of their child. *(From Program Philosophy, BC IDP Manual, March 1997)*

The Infant Development Program staff work with families where there is an infant from birth to three years of age who is experiencing an identified developmental delay in one or more skill areas. Parents are provided with information about normal development developmental delays and handicapping conditions and community resources relevant to their child's difficulty. Also offered are emotional support and the opportunity to meet other families in similar situations. Infant Development Consultants work with the infants to make ongoing assessments of their progress, and to provide appropriate educational programs to aid the families in improving the children's developmental outcome.

The Infant Development Program is funded by the Ministry for Children and Families and is contracted to serve 156 families per year. Referrals come directly to IDP from any source. Monthly statistics re: wait list and caseload reconciliation data was sent to the Ministry monthly.

There was a total of 189 referrals received this year. Of the 189 referrals, 106 were assigned to caseload, and the remainder were monitored on the wait list. Most of these families received interim services such as playgroup, physiotherapy consultation and referrals to other community services. Public health nurses continued to refer most babies to the program at 31%. More than half of the infants referred (51%) were under 6 months old at time of referral. The most common reasons for referral were developmental delay in more than one area and extreme prematurity with medical complications (19%). Most of these children will eventually receive a diagnosis. Approximately 60% of families referred were considered high risk as defined by Provincial IDP criterion. (e.g. 27% ESL, 16% infants in care, 10.5% single parent family)

Approximately 80% (151) of the families referred to the program this year resided in the Newton / Whalley areas of Surrey. Residents of South Surrey / White Rock accounted for 10.5% (20) of the referrals, with the remainder of 9.5% (18) living in Cloverdale & Fleetwood. Ratio males to females has remained constant over the years with males accounting for 55% of the referrals and females 45%.

There were 141 discharges from IDP this year. Over 27% left because they passed their third birthday and were no longer eligible for IDP services. The majority of these children continued to require support upon discharge. Sixteen percent attended a child care facility with Supported Child Care, 47 % were placed without supports, and 37% did not choose child care placements. A further 25% moved out of the catchment area, illustrating the transient nature of the families served by IDP.

The Infant Development Program provided direct service to 369 families this year. This is a small decrease in numbers due to a temporary decrease in staff availability as a result of a maternity leave. Relief staff required a training period of 10 weeks.

There was an average of 101 families waiting for service each month, which is an increase of 13.5% over last year (average of 89 families per month). The average wait time from referral to active caseload was 7 months, (one month > last year) with a range of 3 to 15 months (excludes IDP transfers and re-referrals).

All families who leave the program are surveyed the month they are discharged. This year there was a 29% return rate. Ninety-seven (97% responded positively to questions re: Family Centred Care practices, 84% reported that they were more optimistic about their child's future, and 81% reported that they learned how to advocate for their child's needs. Responses were positive re: knowledge and qualifications of the Consultant and the general quality of services provided. Most valuable services from a family perspective were: Developmental Assessments (29%), Activity Suggestions (28%) and Family / Personal Support (23%).

Referring professionals were also surveyed. Thirty-three percent (33%) returned surveys. The majority of respondents (59%) felt that waiting for IDP services was detrimental to the growth and development of the child. When asked what they liked least about the program, 78% indicated the long wait list. Responses were overwhelmingly positive re: the qualifications and knowledge of the Consultants and the quality of services provided. Despite the long wait, 94% said they would make a referral to the program in the future. Professionals listed the most valuable services provided as: Activity Suggestions (84%), Developmental Assessments (69%) and Family / Personal Support (69%)

Effective Early Intervention has far-reaching positive ramifications on the lives of individuals and their families. Long term goals of the Infant Development Program are:

- To increase the capacity of individuals with disabilities to live as independently as possible.
- To improve quality of life for individuals with disabilities.
- To build inclusive communities.

More immediate measurable outcomes which ultimately result in the above are:

- To maintain / improve healthy family relationships.
- To improve parent / infant attachment.
- To increase the capacity of families to advocate for their children and form effective partnerships.
- To increase families' knowledge of their children's development and thereby optimize their developmental outcomes.
- To decrease the incidence of secondary disabilities.

The Infant Development Program made measurable progress toward these outcomes this year and will continue to find ways and means to improve service with these outcomes in mind. Given the large number of families where English is a second language, translation and interpretation services, particularly in Punjabi, are necessary to ensure that all families, regardless of background or education level, receive the same high quality of Family Centred service.

RESOURCES	ACTIVITIES	OUTPUTS	PROGRAM OUTCOMES	CLIENT OUTCOMES
Staff	**Client Services**	**Client Services**	**Client Services**	
❖ 99/100: 6.4 FTE IDCs 98/99: 6.6 FTE IDCs 99/00: 0.66 FTE Program Manager	❖ Visit families in their homes	❖ 99/00: 2247 homes visited 98/99: 2471 homes visited 97/98: 2586 homes visited	❖ 9.1% decrease in # homes visited - 1 new staff training for 10 weeks for maternity leave relief; not visiting homes	
❖ 99/00: 1 FTE secretary 98/99: 1 FTE secretary	❖ Host parent / child playgroups	❖ 99/00: 89 playgroups 98/99: 98 playgroups (estimate only)	❖ 9.2% decrease # playgroups - #98/99 estimate only), 1 playgroup closed for August	
MCF funding				
❖ 99/00: $468,930.00 98/99: $476,071.08	❖ Take and prioritize referrals to IDP	❖ 99/00: 189 referrals 98/99: 204 referrals 97/98: 199 referrals	❖ 7.4% decrease # referrals - Referrals fairly stable last 5 years; more acute referrals; consulting more with PHNs with borderline infants (ASQ training)	
❖ Toys and equipment ❖ Resource Library ❖ Office, supplies, equipment	❖ Administer / interpret developmental assessments	❖ 99/00: 264 done 98/99: 296 done	❖ 10.8% decrease assessments - Coincides with 10 week staff training; new consultant not doing assessments	
❖ Staff cars ❖ Physiotherapy consultation	❖ Develop individual home activity plans	❖ 99/00: 369 done 98/99: 395 done	❖ 6.6% decrease home activity plans - Coincides with fewer families served due to 10 week staff training	
❖ Occupational consultation ❖ Local Advisory Committee			❖ 31% increase in FSPs - Instituted protocol to monitor this more carefully	
❖ Provincial Steering Committee ❖ Provincial Advisor ❖ Regional Advisor	❖ Facilitate and record Family Service Plans	❖ 99/00: 133 done 98/99: 92 done		

RESOURCES	ACTIVITIES	OUTPUTS	PROGRAM OUTCOMES	CLIENT OUTCOMES
	❖ Provide Physiotherapy consultation	❖ 99/00: 210 consultations 98/99: 360 consultations (estimate only)	❖ 41% decrease physiotherapy consultations - 1 staff training for 10 weeks, therefore no PT consults - More children seen for regular therapy by SFCDC - # last year estimate only; accuracy?	
	❖ Provide Occupational Therapy consultation	❖ 99/00: 52 consultations provided 98/99: 100 consultations provided (estimate only)	❖ 48% decrease in consultations - 1 staff training for 10 weeks, therefore no PT consults - More children seen for regular therapy by SFCDC - # last year estimate only; accuracy?	
	❖ Make referrals to community services	❖ 98/99: 345 referrals made 99/00: 510 referrals made	❖ 32% decrease In # referrals made - Staff not consistently or accurately recording referrals on monthly stats - Children remaining on program longer; most referrals made early on	
	❖ Assist with and document transition plans	❖ 99/00: 141 plans completed 98/99: 137 plans completed	❖ 1.5% increase in number of plans completed - 1 staff 10 weeks training, therefore is an actual increase in # transition plans	

RESOURCES	ACTIVITIES	OUTPUTS	PROGRAM OUTCOMES	CLIENT OUTCOMES
	❖ Respond to public enquiries ❖ Share facilities	❖ Ongoing ❖ 4 community groups use IDP space on a regular basis	❖ 100% children closed had transition plan documented	
	❖ Participate on community committees, working groups, advisory committees	❖ 99/00:16 groups 98/99: 9 groups	❖ 44% increase in participation on committees; etc. - More consultation for purposes of collaboration to manage waitlist - More invitation from community agencies to sit on LAC MCF consultation forums	
	❖ Attend conferences, workshops, and inservices	❖ 99/00: 60 workshops (421 hours) 98/99: 57 workshops	❖ Stable	
	❖ Maintain COA Accreditation Standards Attend CQI Reviews Attend Health and Safety meetings Attend Risk Management meetings Attend Fiscal Responsibility meetings Review standards for compliance	Quarterly Monthly Quarterly Quarterly Twice per year	❖ Monitored and maintained a high standard of quality as determined by the CQI process and regular review of the COA standards for IDP	

RESOURCES	ACTIVITIES	OUTPUTS	PROGRAM OUTCOMES	CLIENT OUTCOMES
❖ Survey professionals	❖ 99/00: 97 referring professionals surveyed - 33% return rate 98/99: 92 referring - professionals surveyed 31.5% return rate	❖ Stable 100 % referring professionals surveyed at year end. ❖ 59% felt waitlist services beneficial ❖ 91% said IDP staff available to consult/communicate with them ❖ 59% felt wait detrimental to growth and development ❖ 94% felt IDCs knowledgeable re: disabilities ❖ 97% felt IDCs knowledgeable re: child development ❖ 81% felt IDP contributes to community awareness ❖ 59% participated in community ed. presented by IDP - Mostly PHNs attending ASQ training - l00% participants indicated ed. was instructive and meaningful to work and is valid activity for IDP ❖ 3% indicated wait list deterred them from referring to IDP ❖ 94% said they would refer again	❖ 91% felt IDP contributes to positive developmental changes ❖ 97% felt It IDP contributes to parents' knowledge of child's development ❖ 97% felt IDP contributes to parents' awareness of community resources ❖ 78% felt that families learn to advocate for their children's needs ❖ 81% felt IDP helped parents feel more optimistic about their child's future.	

RESOURCES	ACTIVITIES	OUTPUTS	PROGRAM OUTCOMES	CLIENT OUTCOMES
	❖ Survey Families	❖ 99/00: 107 families surveyed 31% return rate 98/99:124 families surveyed 33% return rate	❖ 14% decrease in # families surveyed - Fewer families closed - More acute infants, families remain on caseload longer - Return rate stable ❖ 84% felt IDP responsive to needs while on wait list ❖ 97% felt IDC knowledgeable re: disabilities ❖ 97% given sufficient and accurate info re: IDP at time of referral ❖ 97% felt IDC knowledgeable re: child development ❖ Most valued services: ❖ Developmental assessments (94%) ❖ Dev. activity suggestions (90%) ❖ Family/Personal support (74%)	❖ Maintained / improved healthy family relationships. - 97% responded "yes" to questions re: family Centred Care practices ❖ Improved Parent / infant attachment - 84% reported that they were more optimistic about their child's future. ❖ Increased capacity of families to serve as advocates for their children and form effective community partnerships. ❖ Families reached goals as determined by their FSPs - 133 FSPs completed. Goals were met, revised or progress was made ❖ Increased family's ability to optimize their child's development - 84% reported that they learned how to help their child learn new things ❖ Decreased incidence of secondary disabilities - 311 referral to other services

RESOURCES	ACTIVITIES	OUTPUTS	PROGRAM OUTCOMES	CLIENT OUTCOMES
	❖ Participate in staff meetings ❖ Plan and present information to groups of parents ❖ Plan and present information to professionals	❖ Weekly ❖ 99/00: 24 presentations made to parents Most of these were done at "Well Baby" clinics re: typical development ❖ 99/00:12 presentations made to professionals 50% ASQ training for PHNs 25% ECE training in disabilities 25% general presentations re: IDP, development, and attachment	❖ Improved information sharing ❖ Increased team building ❖ Increased peer support ❖ Increased supervision ❖ Increased prevention of benign delays ❖ Increased promotion of IDP ❖ Increased early identification of delays ❖ Increased community development ❖ Increased collaboration /liaison with other professionals ❖ Increased promotion of IDP ❖ Increased community awareness of disabilities	❖ 31% increase in FSPs completed and peer reviewed

SECTION II STAFF

INTRODUCTION

The Infant Development Program staff has a multi-faceted job in this family-centred home-based program. One major aspect of the job involves working with the family to develop an individualized program for the infant that will promote his/her development in major skill areas. To develop an individualized program, the staff ensures:

a) family needs and priorities are assessed regularly and determine program focus;

b) the infant is assessed on a regular basis by standardized assessments or checklists approved by the family;

c) input from appropriate consulting professionals is actively pursued;

d) a range of resource materials and programs of instruction relating to normal and atypical development are utilized.

Ongoing evaluation of short-term and long-term goals and methods of attainment, are worked on with the family during the course of home visits. The program is continually revised in consultation with the family and consulting professionals, to meet the changing development and needs of the infant.

In collaboration with the family, medical assessments are sought throughout the infant's stay in the program. At times limited resources in some areas make it difficult to obtain comprehensive assessment and diagnostic services but the program staff are aware of the importance of sound diagnostic and treatment procedures. It is important for staff to support referrals to specialists such as paediatric physiotherapists, speech and language pathologists, occupational therapists, and social workers, etc. The active participation by these specialists in planning the individual program for each child is encouraged by staff and must be sensitive to family need. Most professionals working with families with very young children recognize the need for families to live their lives as normally as possible. Therapists and IDP staff therefore collaborate on behalf of families they serve to avoid overwhelming families and increasing stresses on them. Recent research (Rossetti, 1994) and our own findings in B.C. (UBC Summer Institute 1987) support a transdisciplinary approach to intervention with young children and their families.

The second major aspect of the job is that the Infant Development Program staff must provide expertise on the resources available in the community for the family and the infant. Staff provide the parents with information about various programs, policies and services that may pertain to the family's needs. As well, staff, in consultation with other professionals, help the family learn more about a disability and the emotions and attitudes which may occur when an infant is identified as having a disability. The Infant Development Program staff are generalists who help channel the family to necessary services and information for the effective care of a child with special developmental needs.

GUIDELINES FOR HIRING AND TRAINING IDP STAFF

Recruitment and maintenance of qualified and competent staff has been pursued through a number of organizational methods. The Regional Advisor is available to assist with this process. Information relating to training is available on the IDP website www.idpofbc.ca and job postings can be posted on the web.

A. It is recommended that societies and Local Advisory Committees establish hiring committees comprised of parents and professionals, to screen, select and hire staff and to monitor their on-the-job performance. A criminal record check must be done.

B. Guidelines, job descriptions, and relevant criteria to be considered when hiring are described in this Manual.

C. All new staff are to be provided with a practicum placement at the beginning of their employment. Evaluations are made during that time and throughout an initial six--month probationary period by the Program Supervisor, Local Advisory Committee, and Regional and/or Provincial Advisor, if requested.

D. An In-service program of ongoing education in the field of infant development has been set up provincially and attendance is strongly recommended for all staff.

E. An Institute on Infant Development is held at UBC annually. Staff participation is strongly recommended.

F. A one year Certificate or 2 year Diploma in Infant Development is available through the Faculty of Education at UBC For more information contact the UBC website. It is envisioned that in future, employment in an IDP will depend on successful completion of the Diploma.

G. The BCAIDC is a professional association concerned with ethics and professional standards of practice. All IDP Consultants are encouraged to become members. It is expected that there will be a certification process developed by the BCAIDC, the Provincial Steering Committee, and UBC in the future.

The quality of the B.C. Infant Development Program rests upon the combination of the professional competence and training of the staff and their firmly rooted commitment to the family as the primary agency responsible for the care of the child and for the development of the child's psychological and physical potential.

INFANT DEVELOPMENT PROGRAM SUPERVISOR - JOB DESCRIPTION

 Must add agency job description and put on agency letter head.

Within the guidelines established by the Provincial Steering Committee, the Supervisor of the Infant Development Program will provide services to infants and their families that will facilitate the development of the infant. The Supervisor is responsible to the society and works under the direction and with the support of that society and the Local Advisory Committee. The job activities have been defined under clinical, community, administration and reflective supervision headings for clarity.

The IDP supervisor is a professional role and all supervisors should maintain a caseload to ensure experience with direct service to families and the community. In very large IDPs this caseload may be small or direct family work may be done through caseload management strategies.

A. CLINICAL

1. Supports the family in developing and maintaining loving relationships with their child.
2. Assists the family in planning and providing experiences in the home and community which will encourage the growth and development of the infant.
3. Responsible for recording home visits, assessing the development of the child, developing a program plan and ensuring that parents and relevant professionals are sent infant progress reports as desired by parents.
4. Responsible for supporting parents to obtain the best services for the child.
5. Responsible for including parents in any decision making process regarding the infant's education, social, or health services.
6. Responsible for assisting parents to determine how best to co-ordinate services.
7. Responsible for informing the family, when appropriate, of social and educational trends in service provision for persons with disabilities. Assists the family in understanding how inclusion may be put into daily practice.
8. Responsible for loaning appropriate books, video tapes, and information to families which may assist them in understanding more about child development, a specific disabling condition and the impact a disability may have on normal growth and development and on family life.
9. Responsible for lending developmentally and individually appropriate toys and assisting the family to help the infant use the toys in an explorative way.
10. Responsible for facilitating the introduction of the family to other parents for support and information, if the family so desires.
11. Responsible for informing the family of educational, health and social opportunities such as playgroup, preschool or daycare available to their infant as he/she grows older.
12. Responsible for assisting the family in the transition process between the IDP and any other service.

B. COMMUNITY ACTIVITIES

1. Responsible for introducing the family to community resources which will be of benefit and for assisting the family to use these resources effectively.
2. Responsible for setting up parent education and parent support programs and/or encouraging the development of community programs which will supplement the in-home education (e.g. lectures, workshops, counselling groups).
3. Responsible for developing with parents, group experiences for parents and infants, when and where appropriate (e.g. Parent and Tot groups).
4. Responsible for keeping the community, including other professionals, informed of the progress and benefits of the Infant Development Program (e.g. Annual Report), and to facilitate inter-agency collaboration.
5. Responsible for continuing his/her own professional development, i.e. reading, course work, sharing information with other professionals in the field, attending regular inservice training and the UBC Summer Institute on Infant Development coordinated by the Provincial and Regional Advisors.

C. ADMINISTRATION

1. Supervision of Infant Development Consultant(s) including hiring, orientation, ongoing training, monitoring and evaluation of job related activities.
2. Supervisors must review all files quarterly. For sole-charge programs, this is the responsibility of the agency administrator.
3. Caseload and wait list management for all children receiving service from the IDP
4. Record keeping including monthly and annual statistics, central registry, and reports required by the sponsoring society, Provincial/Regional Advisors, and Ministry for Children and Family Development.
5. Responsible for ordering and maintaining up-to-date program resources, e.g. toys, videos, books, journals and equipment.
6. Budget and long term planning in collaboration with the sponsoring society.
7. Developing and maintaining family-centered partnerships with parents, community professionals and agencies involved in service provision to young children and their families.
8. Participates in developing inter-agency protocols for service coordination to ensure that professionals involved with the families work effectively together.
9. Program evaluation which should include parent and professional surveys, participation in accreditation, the Mitchell Evaluation, and other evaluations determined by the sponsoring society.

INFANT DEVELOPMENT PROGRAM CONSULTANT - JOB DESCRIPTION

 Must add agency job description and put on agency letter head.

The Consultant will have an assigned caseload under the direction of the Program Supervisor.

A. CLINICAL

1. Supports the family in developing and maintaining loving relationships with their child.
2. Assists the family in planning and providing experiences in the home and community which will encourage the growth and development of the infant.
3. Responsible for recording home visits, assessing the development of the child, developing a program plan and ensuring that parents and relevant professionals are sent infant progress reports as desired by parents.
4. Responsible for supporting parents to obtain the best possible services for the child.
5. Responsible for including parents in any decision making process regarding the infant's education, social or health services.
6. Responsible for assisting parents to determine how to best coordinate services.
7. Responsible for informing the family, when appropriate, of social and educational trends in service provision for persons with disabilities. Assists the family in understanding how inclusion may be put into daily practice.
8. Responsible for loaning appropriate books, video tapes and information which may assist families in understanding more about child development, a specific disabling condition, and the impact a disability may have on normal growth and development and on family life.
9. Responsible for lending developmentally- and individually-appropriate toys and assisting the family to help the infant use the toys in an explorative way.
10. Responsible for facilitating the introduction of the family to other parents for support and information, if the family so desires.
11. Responsible for informing the family of education, health and social opportunities such as playgroup, preschool or daycare available to their infant as he/she grows older.
12. Responsible for assisting the family in the transition process between IDP and any other service.

B. COMMUNITY ACTIVITIES

1. Responsible for introducing the family to community resources which will be of benefit and for assisting the family to use these resources effectively.
2. Assists the supervisor in setting up parent education and parent support programs and/or encouraging the development of community programs which will supplement in-home education (e.g. lectures, workshops, counselling groups).
3. Assists the supervisor in developing, when and where appropriate, group experiences for parents and infants.
4. Responsible for continuing his/her own professional development (e.g. reading, course work, sharing information with other professionals in the field), and for attending staff meetings as they are set up by the supervisor, the Provincial and Regional Inservice. Attendance at the UBC Summer Institute on Infant Development is highly recommended.

INFANT DEVELOPMENT PROGRAM SOLE CHARGE CONSULTANT – JOB DESCRIPTION

Within the Guidelines established by the Provincial Steering Committee, the Sole Charge Consultant will provide services to infants and their families that will facilitate the development of the infant. The Sole Charge Consultant is responsible to the society and works under the direction and with the support of that society and the Local Advisory Committee. The job activities have been defined under clinical, community and administration headings for clarity.

CLINICAL

1. Supports the family in developing and maintaining loving relationships with their child
2. Assists the family in planning and providing experiences in the home and community which will encourage the growth and development of the infant.
3. Responsible for recording home visits, assessing the development of the child, and ensuring that parents and relevant professionals are sent reports twice a year regarding the progress of the infant.
4. Responsible for supporting parents to obtain the best possible diagnostic assessments and medical and related services for the child.
5. Responsible for encouraging parents to take part in any decision making process regarding the infant's education, social, or health services.
6. Responsible for assisting parents to determine how best to co-ordinate services
7. Responsible for informing the family when appropriate of social and educational trends in service provision for persons with disabilities, i.e. normalization and integration. Assists the family in understanding how this philosophy may be put into daily practice.
8. Responsible for loaning appropriate books, video tapes, and information to families which may assist them in understanding more about child development, a specific disabling condition and the impact a disability may have on normal growth and development and on family life.
9. Responsible for lending age-appropriate toys and assisting the family to help the infant use the toys in an explorative way.
10. Responsible for introducing the family to other parents for support and information, if desired.
11. Responsible for informing the family of educational, health and social services available to their infant as he/she grows older.
12. Responsible for ensuring that the family is assisted in selecting an appropriate placement for preschool and that transition procedures between the IDP, preschool and/or Supported Child Care are in place.

COMMUNITY ACTIVITIES

1. Responsible for introducing the family to community resources which will be of benefit and for assisting the family to use these resources effectively.

2. Responsible for setting up parent education and parent support programmes and/or encouraging the development of community programmes which will supplement the in-home education (e.g. lectures, workshops, counseling groups)

3. Responsible for developing with parents, group experiences for parents and infants, when and where appropriate (e.g. Parent and Tot groups).

4. Responsible for keeping the community, including other professionals, informed of the progress and benefits of the Infant Development Programme (e.g. Annual Report), and to facilitate inter-agency collaboration.

5. Responsible for continuing his/her own professional development, i.e. reading, course work, sharing information with other professionals in the field, attending regular inservice training and the U.B.C. Summer Institute on Infant Development coordinated by the Provincial and Regional Advisors.

ADMINISTRATION

1. Caseload and wait list management for all children receiving service from the I.D.P.

2. Record keeping including monthly and annual statistics, central registry, and reports required by the sponsoring society, Provincial/Regional Advisors, and Ministry for Children and Families.

3. Responsible for ordering and maintaining up to date programme resources, e.g. toys, videos, books, journals and equipment.

4. Budget and long term planning in collaboration with the sponsoring society.

5. Developing and maintaining family-centred partnerships with parents, community professionals and agencies involved in service provision to young children and their families.

6. Participating in developing inter-agency protocols for service co-ordination to ensure that professionals involved with the families work effectively together.

7. Programme evaluation which should include parent and professional surveys, the Mitchell Evaluation, and other evaluations determined by the sponsoring society.

STAFF QUALIFICATIONS

It is expected that all staff employed as Infant Development Consultants will have a degree in a field related to child development or the equivalent. It is also expected that staff will pursue the Certificate and Diploma in Infant Development offered through the University of British Columbia.

In order to assist in the selection of personnel, the following criteria should be considered:

1. knowledge of and commitment to the principles and practices of family centred care;
2. a sensitivity to the real needs of the family, which will change over time;
3. willingness to go beyond traditional approaches to support families, even at the cost of personal convenience (e.g. flexibility in working hours);
4. possession of non-judgmental and genuinely positive attitudes toward persons with disabilities and their families;
5. competency, acquired through training, in principles and techniques of early intervention in delayed development and working with families;
6. practical experience in working with families with infants with a disability or delay;
7. freedom from stereotypes about disabilities;
8. knowledge of the broader medical, social, educational, and behavioural aspects of disabling conditions;
9. knowledge of resources in the broadest sense (i.e. agencies, services, long-range local prospects, reading materials, "gadgets" useful in home management, etc.);
10. great patience.

These criteria are applicable even though a large proportion of infants referred to an Infant Development Program are not diagnosed as disabled.

Individuals considered for the staff positions must also subscribe to the following principles:

1. staff and parents work in partnership in program planning and recognize that parents have ultimate responsibility for their children.
2. a developmental disability may have life-long ramifications;
3. effective management of personal time and energy is essential to balance the demands of variable working conditions (e.g. caseload, hours, place, personnel).

SUGGESTED HIRING PROCEDURES

HIRING COMMITTEE

Supervisor Consultant
The supervisory position involves a diversity of inter-professional contacts within and outside of the program. Families involved in the program represent many backgrounds; therefore, it is recommended that the Hiring Committee include representation as follows:

- parent representative from the Local Advisory Committee
- professional representative from the Local Advisory Committee
- society representative (can be one of above)

The Provincial Advisor, Regional Advisor and/or present or past Infant Development Program staff may assist with the following steps, if requested.

- reviewing criteria for selection of staff with the L.A.C. and Hiring Committee
- advertising and screening applicants

IDP Consultant
The Supervisor of the program should have a major responsibility in the screening and hiring of IDP Consultants. However, it is recommended that the above described Hiring Committee participate in this process, and in the evaluation of the probationary period.

Advertising
Typically, an advertisement is placed under the Professional / Management column of the local and provincial newspaper, worded as follows:

Infant Development Program: Supervisor / IDP Consultant position available in (community), effective (date). Applicants should have a degree in a field related to early childhood development (e.g. therapy, education, nursing) and should have demonstrated practical experience in working with developmentally-delayed infants, their families, and other professionals. Send full resume to Box (number) by (date). This position will remain open until a suitable applicant is found.

Other Methods to Encourage Applications
In addition to responses from newspaper advertisements, the committee may encourage applications from a number of other sources. These may include the following:

- **Provincial Advisor/Regional Advisor** - the Provincial Advisor and/or Regional Advisors receive a number of resumes from interested professionals and will direct appropriate resumes when requested.
- **Post on www.idpofbc.ca website**
- **Infant Development Program** - each program receives enquiries regarding employment and should be asked to forward appropriate resumes.
- **Training Facilities** - Faculties in the Health Sciences, Education and Psychology departments may provide some employment services for students. Recent graduates without working experience however, should be very carefully screened.
- **Professional Associations** - (e.g. R.S.W., C.A.O.T., B.C.T.F., R.N.A.B.C.), generally provide some employment services or offer opportunities for advertisements in professional journals or newsletters.

Screening Applicants

When the closing date for applications is over, it is suggested that all Hiring Committee members thoroughly review all applications prior to setting up an interviewing schedule. This may prevent interviewing persons who do not have the qualifications for this work, as well as giving the committee the preliminary experience of defining the necessary criteria for the position in relation to their community. If insufficient or inappropriate applications have been made, a decision for further advertising may be made at this time. For assistant positions, the responsibility for initial screening may be allotted to program supervisors. However, all applications must be available to the Hiring Committee for review if necessary.

Resume

Resumes should provide enough information about the professional training and work-related experiences of the applicant to allow the Hiring Committee to make some fair judgment as to whether or not to interview. Successful applicants have generally submitted resumes which have some or all of these features:

- letter expressing a strong interest in the field of early intervention in delayed development and a desire to work with infants and families
- typed, well-organized resume, which stresses professional training and work experiences related to the position
- references which are written by past employers who were in a position to judge expertise, ability to relate and ability to function independently. It is strongly recommended that the committee contact all references supplied for verbal confirmation of the applicant's competencies and some discussion of how the person may perform as an Infant Development Program Consultant.
- See Appendix II-A **Job Reference Check** (page 61)

The Interview

Prior to interviewing, the committee should determine who will chair the session, which questions should be asked of all applicants, and how to judge responses fairly. A suggested list of questions, Appendix II-B **Questions for Employment Interviews** (page 62) and Appendix II-C **Applicant Assessment Form** (page 63) are included for a guide. The Applicant Assessment Form may be used as a rough guide to ascertain specific skills and strengths as they relate to differences between persons interviewed by the committee. It is recommended that the applicants who are selected for interviews be sent information about the program prior to the interview. This information might include the Guidelines for the Infant Development Program, job description for the position or other relevant material.

It is recommended that at least one to one-and-a-half hours be allotted for each interview. An approximate breakdown of the time is as follows:

Pre-interview

10 - 15 minutes: Committee reviews and discusses resume, decides which areas should be the focus of the question/answer period. During this time, further information on the program could be given to the applicant to read, prior to meeting with the committee.

Interview

30 - 40 minutes: The applicant should be

- made comfortable,
- encouraged and given ample opportunity to respond to questions and to expand on areas as well as to question the Committee with regard to the position. At least 80% of the interview should be applicant response.

Post interview

10 - 15 minutes: Committee fills in **Applicant Assessment Form** (Appendix II-C), (page 63) and discusses the relative areas of strength and weakness of the applicant.

Decision to Hire: Probationary Period

A consensus should be reached prior to making the decision to hire, and references checked.

As the role of the IDP consultant is very complex, it may be advisable to have an extended probationary period to assure that the person fits the job. Probationary period is agency specific.

It is recommended that these following items be decided upon by the society before hiring and discussed with staff when hired.

- hiring procedures
- length of probationary period
- evaluation format
- benefits
- insurance
- hours of work
- statutory holidays
- sick leave
- annual vacation leave
- mileage
- leave of absence
- confidentiality
- maternity leave
- salary - to be considered in light of training and job-related experience
- scale
- increments
- pay periods
- See section on Health & Safety on page 89
- Ideally, discussion of these items with staff will foster a climate of open communication and support, enabling the Hiring Committee to freely discuss areas in which staff may need more direction or support.

It is important to notify the Office of the Provincial Advisor and the Regional Advisor of newly hired staff so they can attend training, and changes can be made to the provincial contact list.

INITIAL PRACTICUM PLACEMENT

Rationale

As soon as possible after they have been hired, the Infant Development Program staff are placed in a practicum training placement, for one to two months. It is important that the staff do not carry a caseload at this time as this is a supervised learning time. *It is recommended in programs with Sole Charge, the staff contact the Regional Advisor as soon as possible to set up supervised opportunities for training. Major reasons underlie this practicum training placement.

1. Staff members come from varied professional backgrounds and require an intensive experience with existing Infant Development Programs. As well, practical experience with local community resources must be acquired at this time.

2. Close association with the placement program staff, Senior IDP staff and/or the Regional Advisor, allows for exchanges of information and an opportunity to raise questions related to direct service.

3. The IDP staff at the practicum site, Senior IDP staff and/or the Regional Advisor have an opportunity to see the new staff in a variety of new situations and to informally evaluate performance, attitudes, strengths and training needs.

4. Most Infant Development Program staff must function in situations requiring independence and flexibility; these initial training placements help build a base of self-reliance in a context of support and informative experience.

Methods and Procedures

The initial practicum placements for program supervisors are individually designed after an assessment by the Local Advisory Committee, Senior IDP staff and/or the Regional Advisor, of the staff's experience, training and the resources available for this in the community. Practica for assistants will be the responsibility of program supervisors, although input from the Local Advisory Committee and Regional Advisor is recommended. Practicum placements usually cover a period of one month to two months prior to the provision of direct service by that worker. This practicum includes:

1. directed study areas, including Gesell (please see **Gesell Orientation sheets**, Appendix II-D (page 64) and Appendix II-E) (page 65)

2. familiarization with local resources

3. placement with existing programs - see **Observation Record for Home Visits**, Appendix II-F (page 66)

4. review by Regional Advisor and/or IDP supervisor of practicum placement

5. introduction to special Provincial Services

Please see **Community Resources** Appendix II-G (page 67), **Orientation Checklist** Appendix II-H (page 69) and **Local Community Information** Appendix II-I (page 77) which cover many aspects of areas to be covered during the practicum.

During the practicum placements, informal evaluations of the new worker are carried out. The supervisor of the placement program, senior IDP staff and/or the Regional Advisor evaluate the attitudes and performance of the new staff and communicate their evaluation to him/her and to the Sponsoring Society. Through the medium of the participation of the Local Advisory Committee in setting up the local practicum experiences, there is an opportunity for informal evaluation at that level. For example, the Public Health Nurse representative on the Local Advisory Committee would have an opportunity to assess staff interacting with Public Health Nurses and other professionals in the community. It is recommended that questionnaires be distributed by the Hiring Committee to:

- Probationary staff
- Local Advisory Committee
- Parents receiving service

Annual Review

The **Annual Review of Infant Development Program Staff** Appendix II-J (page 78) should be started during the probationary period. Methods of evaluation and methods of interpretation of results should be shared with staff during the probationary period. At this time, additional training needs are assessed and suggestions drawn up for the provision of future training within the staff's home community, or at the Regional and Provincial level.

It is important for staff to develop the practice of reflective learning. The evaluation provides an opportunity to do this.

INSERVICE TRAINING

Provincial and Regional Inservice

Knowledge in the fields of normal child development, developmental disability, assessment, programming, teaching techniques and patterns of family interaction are growing extremely rapidly. In order to provide up-to-date information to Infant Development Program staff, inservice training is held in Vancouver at the University of British Columbia two times per year.

The three to four day inservice workshops are organized by the Provincial/Regional Advisors using input from the staff as one basis for determining the content of the training. A variety of formats (lectures, small groups, conferences, interagency exchanges) are utilized in accordance with the needs of the staff, the material to be presented and the resources available. All staff are encouraged to attend. Part-time, as well as full-time staff carry equal responsibility in service provision to individual families. Regional Inservices may be held but are usually less frequent and of shorter duration. Local issues and resources may be dealt with during these meetings.

CERTIFICATE / DIPLOMA IN INFANT DEVELOPMENT / SUMMER INSTITUTE

A one year certificate and a two-year diploma in Infant Development is available through the Faculty of Education at the University of British Columbia. A two-week Summer Institute which forms part of the course work for the Diploma takes place at UBC every July. This provides credits towards the certificate/diploma. Professors who teach at the Institute have an international reputation in the field of early intervention and course work presented is tailored to meet the needs of Infant Development Program staff. All staff employed in Infant Development Programs are strongly advised to attend these institutes. It is envisioned that in the future, employment in an Infant Development Program will depend upon successful completion of the certificate/diploma.

PREVIOUS SUMMER INSTITUTES

1983	Rose Bromwich	Working with Parents of Handicapped Children SPED 348
1983	Elinor Ames	Education of Atypical Infants and Children SPED 406
1984	Diane Bricker	Programming in Special Education Developing Perspectives SPED 344
1985	Carl Dunst	Academic Curricula in Special Education Developing Perspectives SPED 346
1986	David Mitchell	Mental Retardation SPED 403
1987	Gene Edgar / Rebecca Fewell	Guidance Issues with Handicapped Infants (Observation and Recording) EDYC 438
1988	Rune Simeonsson	Family Focused Interventions ECED 334
1989	Dale Farran	Pre-Kindergarten Curriculum: Exceptional Preschool Children and Their Families ECED 333
1989	Rune Simeonsson	Pre-Kindergarten Instruction: Individualizing Interventions for Handicapped Infants and Their Families ECED 343
1990	Elinor Ames	The Education of Atypical Infants and Children: Normal Development and the Atypical Infant SPED 406
1990	Michael Guralnick	The Exceptional Child in the Regular Classroom: Preschool Mainstreaming and Peer Relations SPED 317
1991	Dale Farran	Working with Parents of Handicapped Children: Infant Development Focus EPSE 348
1991	Michael Guralnick	Kindergarten Curriculum: Promoting Peer-Related Social Development ECED 433

1992	Kofi Marfo	Early Intervention in a Multicultural Society EDCI 396
1993	Carl Dunst	Assessment and Program Planning for Infants and Toddlers ECED 343
1994	Kofi Marfo	Atypical Development and Intervention Practice EPSE 462
1995	Dale Farran	Pre-Kindergarten Curriculum: Exceptional Preschool Children and Their Families ECED 333
1996	Valerie Gonzales	Developmental Processes in the Typical and Atypical Infant EPSE 390
1997	Jane Drummond / Gerard Kysela	Working with Parents of Children with Disabilities: Family Centred Practices in Early Intervention EPSE 348
1998	Rose Bromwich	Working with Families and Their Infants at Risk EPSE 390
1999	Carl Dunst	Evidence-Based Early Intervention Practices ECED 343
2000	Cordelia Robinson	Education of Atypical Infants and Children EPSE 406
2001	Sarah Landy / Roseanne Menna	Working with High Risk Families ECED 343
2002	Ann Reimer Susan Lane / Tanni Anthony	Working with Children with Sensory Disabilities EDUC 449
2003	Sue Yockelson	Curriculum Planning and Implementation for Early Intervention and Early Childhood Special Education ECED 333
2004	Pratibha Reebye	Infant Mental Health in the 21st Century EPSE 380

APPENDIX II-A JOB REFERENCE CHECK

Applicant: _____ Person Contacted: _____

Agency called: _____ Title: _____

Phone No: _____

1. Was applicant employed by your agency? Yes _____ No_____
2. Did you directly supervise this applicant in your agency? Yes _____ No _____
3. What were the dates of employment? From _____ To _____
4. What was the job title? _____

   _____
5. What was the nature of work performed? _____

   _____
6. Were there any promotions? Yes _____ No _____
7. Please describe the circumstances. _____
8. Explain that the applicant has applied to work with a program which supports families with young children with delay or disabilities. What qualities has _____ demonstrated which might benefit her/him in this position of working with families with young children. _____

   _____
9. Describe ability to understand and take directions / work independently: _____

   _____
10. Can you give an example of initiative that _____ demonstrated? _____

    _____
11. How would you describe this individual's relationship with co-workers?_____

    _____
12. How does this individual relate to the professional community? _____

    _____
13. In what areas would you say this employee could improve?_____

    _____
14. What are their greatest skills? _____

    _____
15. How would you rate attendance?_____

    _____
16. What were this person's reasons for leaving your agency? _____

    _____
17. Would you rehire? Yes _____ No _____ Why or why not? _____

Interviewer: _____ Date: _____

APPENDIX II-B QUESTIONS FOR EMPLOYMENT INTERVIEWS

 Add agency questions if different

A list of Staff qualifications should be kept in mind when asking the following questions:

1. After reading the Infant Development Program outline, what do you feel are the goals of the program?
2. What skills do you have to offer to infants and the parents? Knowledge of:
   - family centred practices
   - normal and atypical development in infancy
   - assessment
   - curriculum development
   - intervention strategies
   - community resources
   - social systems theory
   - inclusion
3. In what areas do you feel you need training or additional support, in order to perform the job satisfactorily?
4. How do you perceive the role of parents and other family members in relation to their child's development and parenting as a developmental process?
5. How do you see the parent's role in an Infant Development Program, in relation to:
   - your role
   - assessment and program planning
   - work with other parents
   - monitoring staff effectiveness
   - community involvement
   - advocacy
6. How would you deal with a situation where the parent told you that early intervention was of no value?
7. How would you approach a family whose family doctor suggested to the parents that the child be placed in out of home care?
8. What are your attitudes and values with respect to the rights of persons with disabilities?
9. What resources exist in the community that might help an infant who may be on your caseload?
10. Are you prepared to work on committees whose mandate is related to your own program e.g. preschool, early years initiatives
11. Do you feel it is beneficial to get the parents and children together in groups? If so, why? What methods will you use to help this group come about?
12. What is your knowledge of medical diagnostic assessments and interventions?
13. As the staff of this program you will be involved in administration, record keeping, public awareness and direct casework. What would you consider to be priorities and where do you see you could use assistance in setting priorities?
14. What skills do you have in working with people from diverse backgrounds including social, economic, and particularly in relation to those who have been traditionally disempowered?

APPENDIX II-C APPLICANT ASSESSMENT FORM

If agency has different assessment form, add to this section.

Name of Applicant: _____

Date of Interview: _____

This is a tool to assist Hiring Committees to organize information about applicants and to roughly compare relative strengths and weaknesses among applicants interviewed. Decisions on the selection of staff for Infant Development Programs should be based on the following areas and rated accordingly. This information is confidential.

Training and Experience

	Inadequate				Excellent
1. Academic training	1	2	3	4	5
2. Course work in infant and family development	1	2	3	4	5
3. Experience in programs serving infants with developmental problems and their families	1	2	3	4	5
4. Experience in working with people from diverse social, economic and cultural backgrounds	1	2	3	4	5
5. Experience in facilitating inter-agency collaboration	1	2	3	4	5
6. Supervisory / Management skills	1	2	3	4	5

Personal Attributes

1. Ability to relate with infants, parents and professionals in a warm and caring manner	1	2	3	4	5
2. Self-motivated, well organized, able to work independently	1	2	3	4	5
3. Ability to work with a team	1	2	3	4	5

Total score:_____

Highest possible score: 45

APPENDIX II-D OBSERVATION RECORD FOR A GESELL ASSESSMENT DONE DURING PRACTICUM

New Staff (Name) _____

Practicum Placement (Program Title) _____

Experienced Consultant (Name)_____

Date _____

This record may be used for an observation of Gesell, administration of Gesell, or for writing a Gesell report. Please specify which use in the space provided:

Child Assessed: Chronological Age _____ Corrected Age_____

Key Points _____

_____

_____

_____

Goals for Improvement _____

_____

_____

_____

Comments _____

_____

_____

_____

_____ _____

New Consultant Experienced Consultant

APPENDIX II-E SUMMARY FORM FOR GESELL ASSESSMENTS

It is not necessary to administer or observe an assessment at every age level for training. It is necessary to get a broad understanding of the application of the assessment

Key Age	Observation	Administration	Report Writing
4 weeks (or)	_____	_____	_____

Comments: _____

_____

_____

16 weeks (or)	_____	_____	_____

Comments: _____

_____

_____

28 weeks (or)	_____	_____	_____

Comments: _____

_____

_____

40 weeks (or)	_____	_____	_____

Comments: _____

_____

_____

52 weeks (or)	_____	_____	_____

Comments: _____

_____

_____

18 months (or)	_____	_____	_____

Comments: _____

_____

_____

24 months (or)	_____	_____	_____

Comments: _____

_____

_____

36 months (or)	_____	_____	_____

Comments: _____

_____

_____

APPENDIX II-F OBSERVATION RECORD FOR A HOME VISIT DONE DURING PRACTICUM

New IDP Consultant (Name) _____

Practicum Placement (Program Title) _____

Experienced Consultant (Name) _____

Age of Child: _____ Date of Home Visit: _____

Parent agrees to assist in staff training _____ _____

Home Visit

Diagnosis/Reason for Referral _____

_____

_____

Family Needs/Issues/Goals for Child _____

Intervention Ideas _____

_____

_____

Follow Up _____

_____

_____

Comments _____

_____

_____

This observation record was reviewed for accuracy by the following:

_____	_____	_____
New Consultant	Parent	Experienced Consultant

APPENDIX II-G COMMUNITY RESOURCES TO BE OBSERVED DURING PRACTICUM PLACEMENT

New staff must become acquainted with resources in their community and the specialized provincial resources that may be of assistance to them and to families receiving service. During the course of the initial practicum, new staff should refer to the Community Information Sheet (page 77) to enable the program to systematically collect relevant community information. Primary sources of community information include:

A. Parents - Time with parents who are on the Local Advisory Committee to discuss:

- their expectations of Infant Development Program Consultants
- past experiences with professionals and resources useful to them in their community including regional and provincial resources.

B. Public Health - Services provided that relate to parents and children including as many well-baby clinics as possible and observation of assessments done on infants up to three years of age. Other services in the community such as Pregnancy Outreach Program, Nobody's Perfect, etc. should be looked at. The Public Health liaison on the Local Advisory Committee can help to arrange this.

C. Ministry for Children and Family Development - Orientation on the variety of services provided to families including:

- Supported Child Care
- Family Support Workers
- Child Protection Services
- Homemakers
- Financial Assistance
- Foster Care
- Services for People with Mental Handicap
- Advocate for Service Quality

As with Public Health, the Ministry for Children and Family Development liaison person on the Local Advisory Committee might help set this up.

D. Mental Health Clinics - Early Childhood Clinician, psychological and counselling services available.

E. Ministry for Children and Family Development - Early Intervention Programs -

Early Intervention Programs are funded by MCFD and sponsored by a range of community agencies such as Child Development Centres.

Observation of infant services and children's services, and introduction to assessments used, program planning, teaching techniques and report writing for parents and professionals. Observation of therapy provided

Home visits with therapists during which time the Infant Development Program staff will familiarize him/herself with:

- the role of therapist
- the variety of motor and speech problems and treatment plans
- methods to reinforce physiotherapy or speech prescriptions when home visits commence

Familiarization with other related services such as:

- family support services
- parent meetings and training

F. Day Care/Pre School Programs/Supported Child Care

G. Hospital

- Newborn Nursery
- Intensive Care Nursery - follow up
- Paediatric Ward
- Social Service Department
- Out-patient services available (i.e. physio, O.T., nutritionist)

H. Programs and/or Services in the community for families and infants aged 0-3 years. These may include:

- family resource centres
- parent and tot groups
- CAPC, CPNP, AHS, Healthiest Babies
- YMCA and other community recreation activities
- counselling services
- parent associations
- college course relevant for staff and/or parents

I. Provincial Resources (e.g.) Please request a package from the Provincial Office which has information on some of these services.

- B.C.'s Children's Hospital
- Sunny Hill Health Centre for Children
  - Hearing Loss Resource Team
  - Visually Impaired Program
  - Seating Clinic
  - Feeding Clinic
  - Outreach Services
  - Diagnostic Teams
- Provincial Coordinator of F.A.S. D
- British Columbia Association for Community Living
- Western Institute for the Deaf
- Canadian National Institute for the Blind - Deaf Blind
- Pacific Association for Autistic Citizens
- Cerebral Palsy Association of British Columbia
- Sunny Hill Health Centre for Children
- Elks Family Hearing Resource Centre
- Family Support Institute

APPENDIX II-H ORIENTATION CHECKLIST TO PROGRAM AND COMMUNITY

The purpose of this checklist is to assist newly employed Infant Development Program Consultants to:

1. become acquainted with administrative policies related to the Infant Development Program.
2. ensure relevant areas are covered during the orientation period.
3. identify future training needs.

This form should be reviewed by the Sponsoring Society, Local Advisory Committee and Infant Development Program supervisor or with Regional Advisor for sole-charge programs, at regular intervals.

Section I - Program Administration

			Date Completed
A.	**Initial Conference**		
	a)	Overview of Orientation	_____
	b)	Personnel Policies of Society	_____
		a) Meeting with Executive Director of Society	_____
		b) Car/Professional Liability Insurance	_____
		c) Update Inoculations/TB	_____
B.	**The Infant Development Program**		
	1)	Provincial Background	_____
		a) Background to Infant Development Program	_____
		b) Policy and Procedure Manual	_____
		c) Role of the Provincial Steering Committee, Provincial and Regional Advisors	_____
	2)	Local Organization	
		a) Community Sponsored Program	_____
		b) Relationship with Ministry of Children and Family Development	_____
		c) Funding System	_____
C.	**Infant Development Program office overview**		
	1)	Physical layout and staff introductions	_____
	2)	Communication lines and methods	
		a) Switchboard/Answering Service	_____
		b) Long Distance Procedures	_____
	3)	Clerical Services - Receptionist, typing, filing, photocopying	_____
	4)	Computer / Internet access facilities	_____

D. Services provided by the Infant Development Program **Date Completed**

1) Program Philosophy - Aims and Objectives _____
2) Home Visits _____
3) Group activities (playgroup/Parent Child Mother Goose) _____
4) Referral to Other Agencies _____
5) Parent Meetings/Workshops _____
6) Toy Library _____
7) Book Library _____
8) Community Awareness- links to 0-6 initiatives _____
9) Other _____

E. Geographic area covered by the Infant Development Program

1) In Boundary/Out of Boundary Caseload _____
2) Ministries for Children and Family Development and Health _____
3) Maps- see IDP website www.idpofbc.ca
4) Other IDPs _____

F. Community Resources in area served by the Infant Development Program

1) Tour of Geographic Area _____
2) Health Units - Tour and Introductions _____
   a) Medical Health Officer _____
   b) Supervisor of Nursing _____
   c) Public Health Nurses _____
   d) Paediatric Therapists _____
3) Other Health Related Services
   a) Nutritionist _____
   b) Pregnancy Outreach Program _____
   c) Speech and Language Pathologist _____
   d) Drug and Alcohol Counsellor _____
   e) Mental Health Psychologists and Early Childhood Clinician _____
4) Ministry for Children and Family Development
   a) Regional Office _____
   b) District Office _____
   c) Foster Placement Social Worker _____
   d) Child Protection Resources _____
   e) Community Living Services _____

			Date Completed
5)	Birth Hospital/Paediatric Ward		
	a)	Senior Physicians	_____
	b)	Senior Nursing Staff	_____
	c)	Special care nursery	_____
6)	Community Physicians		
	a)	Paediatricians/other Paediatric Specialist	_____
	b)	General Practitioners	_____
7)	Child Development Centre		
	a)	Executive Director	_____
	b)	Medical Director	_____
	c)	Physiotherapist	_____
	d)	Occupational Therapist	_____
	e)	Speech/Language Pathologist	_____
	f)	Early Childhood Educator	_____
	g)	Social Worker	_____
	h)	Family Support Worker	_____
	i)	Other	_____
8)	Therapy Services in the community		
9)	Association for Community Living		
	a)	Executive Director	_____
	b)	Services for Children	_____
	c)	Services for Adults	_____
10)	Community groups, pre-schools, child care services		
	a)	Mom & Tot Groups, Parent Child Mother Goose	_____
	b)	Family Resource Programs	_____
	c)	Day Care Programs	_____
	d)	Pre-Schools	
11)	Supported Child Care		
	a)	Sponsoring agency	_____
	b)	Supervisor and staff	_____

12) School District

a) Integrated School Services _____

b) Itinerant teachers: Visually Impaired/Hearing Impaired _____

c) Special Education Coordinator & Services _____

13) Local 0-6 Initiatives: See H below.

G. Provincial Resources

The Provincial office IDP maintains a Resource Manual which includes information on most of the following: **Date Completed**

1) Provincial Office Infant Development Program and Regional Advisors _____
2) Provincial Steering Committee IDP _____
3) British Columbia Association for Community Living _____
4) Canadian National Institute for the Blind _____
5) Visually Impaired Program, Sunny Hill _____
6) Pacific Association for Autistic Citizens _____
7) Family Support Institute _____
8) B.C.'s Children's Hospital _____
9) Cerebral Palsy Association of British Columbia _____
10) Sunny Hill Health Centre _____
11) Deaf Children's Society _____
12) Family Hearing Resource Centre _____
13) BCFAS Resource Society _____
14) Adoptive Parents Association of B.C. _____
15) SOFT _____
16) Special Needs Adoptive Parents _____
17) Spina Bifida Association _____
18) Lower Mainland Down Syndrome Society _____
19) Other (specify) _____

H. 0-6 Initiatives

1) Aboriginal Infant Development program _____
2) Aboriginal head start _____
3) Community action program for children (CAPC) _____
4) Canadian prenatal nutrition program (CPNP) _____
5) Brighter Futures _____
6) Learning sites _____

7) Building blocks _____

8) Nobody's Perfect _____

Section II - Skills and Techniques, Self Rating

A. Screening and Assessment

		3 months	6 months
1)	Gesell Developmental Schedules	_____	_____
2)	Hanen Language Program	_____	_____
3)	Carolina Curriculum on Infants and Toddlers	_____	_____
4)	A.E.P.S.- Assessment Evaluation and programming system	_____	_____
5)	(Bricker, 1993)	_____	_____
6)	Transdisciplinary Play-Based Assessment	_____	_____
7)	HAWAII	_____	_____
8)	Oregon	_____	_____
9)	PAN- Parent Assessment of Needs	_____	_____
10)	Caldwell's Home Inventory	_____	_____
11)	Nursing/Child Assessment Training (NCAT)	_____	_____
12)	Bromwich - Parent Behaviour Progression	_____	_____
13)	Parent-Infant Monitoring Ages and Stages Questionnaire ASQ/	_____	_____
14)	Ages and Stages Social Emotional ASQ-SE	_____	_____

Assessments are available from Provincial office or Regional Advisors

B. Home Visiting

		3 months	6 months
1)	Interviewing	_____	_____
2)	Parent information package on IDP	_____	_____
3)	Recording Home Visits	_____	_____
4)	Building Relationships	_____	_____
	a) Child	_____	_____
	b) Parents	_____	_____
	c) Other family members	_____	_____
	d) Other professionals	_____	_____
	e) Reflective supervision opportunities	_____	_____

C. Group Orientation

		3 months	6 months
1)	Parent and Tot Groups	_____	_____
2)	Parent Support Groups	_____	_____
3)	Parent Education (e.g. Nobody's Perfect)	_____	_____
4)	Other (Specify)	_____	_____

D. Record Keeping

			3 months	6 months
1)	Statistics		_____	_____
	a)	Record of Family Contact	_____	_____
	b)	Month End Caseload Statistics	_____	_____
	c)	Central Registry	_____	_____
	d)	Annual Statistics	_____	_____
2)	Individual Files –forms and file management			
	a)	Referral Form	_____	_____
	b)	Consent Form	_____	_____
	c)	Letter to Professionals re Referral	_____	_____
	d)	Letter re Therapy(s)	_____	_____
	e)	Home Visit Records	_____	_____
	f)	Goal Sheets	_____	_____
	g)	Reports on Infant	_____	_____
	h)	Closing Information	_____	_____
3)	Annual Report			
	a)	Infant Development Program Staff	_____	_____
	b)	Local Advisory Committee	_____	_____
	c)	Society	_____	_____

Section III - Teaching Skills, Self Rating

A. Parent Teaching

		3 months	6 months
1)	Normal Growth and Development	_____	_____
2)	Individual differences / temperament	_____	_____
3)	Parent/Infant Interaction	_____	_____
4)	Attachment	_____	_____
5)	Disabilities / Developmental concerns		

a) Intellectual _____ _____
b) Physical _____ _____
c) Hearing _____ _____
d) Visual _____ _____
e) Seizure Disorder _____ _____
f) Multiple _____ _____
g) Developmental Delay _____ _____
h) Medical Syndromes/Diseases _____ _____
i) Prematurity / At-Risk Factors _____ _____
j) FASD / NAS _____ _____

6) Theoretical Framework for Early Intervention
   a) Rationale _____ _____
   b) Research _____ _____
   c) Application _____ _____

7) Adults as Learners - Theories and Practices _____ _____

B. Use of Resources

		3 months	6 months
(1)	Public Health Unit	_____	_____
(2)	Ministry for Children and Family Development, Early Intervention Programs, (Physiotherapy, Occupational Therapy, Speech and Language Pathology Services, Family Support Worker)	_____	_____
(3)	Ministry for Children and Family Development		
	a) Social Workers	_____	_____
	b) Family and Children's Services	_____	_____
	c) Financial Assistance	_____	_____
	d) Community Living Services	_____	_____
(4)	Supported Child Care	_____	_____
(5)	Physicians	_____	_____
(6)	Mental Health Services-Early Childhood Clinician	_____	_____
(7)	Drug and Alcohol Counsellors	_____	_____
(8)	Counselling Services / Bereavement Support	_____	_____
(9)	Homemakers	_____	_____
(10)	Speech and Hearing Clinics	_____	_____

(11)	Pre-School Placement	_____	_____
(12)	Local Region / Parent Rep. Family Support Institute	_____	_____
(13)	Debt Management	_____	_____
(14)	Financial support	_____	_____
(15)	Websites	_____	_____

C. Screening / assessment / diagnostic services, population served, referral procedures, services provided

		3 months	6 months
1)	Community Physicians	_____	_____
2)	Paediatricians	_____	_____
3)	Paediatric Specialists (e.g. neurologist, travelling clinics)	_____	_____
4)	Public Health Screening	_____	_____
5)	Hospital Based Services	_____	_____
	a) local	_____	_____
	b) regional	_____	_____
	c) B.C. Children's Hospital	_____	_____
6)	Ministry for Children and Family Development Early Intervention Program (Physiotherapist, Occupational Therapist, Speech & Language Pathology Services, Family Support Worker)	_____	_____
7)	Speech and Hearing Clinics	_____	_____
8)	Metabolic Screening/Genetic Counselling	_____	_____
9)	Sunny Hill Health Centre Clinics (Outreach and Outpatient, Feeding, Seating, Orthopedic, Vision Consultant, Neuromotor)	_____	_____
10)	Behaviour Consultants on Autism	_____	_____
11)	Autism Resources	_____	_____

APPENDIX II-I LOCAL COMMUNITY INFORMATION

Infant Development Program Consultants, with help and direction from the Local Advisory Committee, should keep an up-to-date file on community resources. When compiling your list of community resources, collect the following information (if possible) for each resource. Some of this may be available from the resource in brochure form. Some of this information will be included in the IDP Parent Information Package.

1. Name, address, telephone number of resource, email, website
2. Contact Person - Name and telephone number:
3. The person most available and knowledgeable to provide information about the resource for staff and/or parent
4. Population - Who does the program serve?
5. Referrals - How are referrals made (self-referral, agency or physician referral, etc.)?
6. Services - What services does the program provide?
7. Time - What hours does the program operate, days of the week, etc?
8. Cost - If there are fees, how are they levied?

Some of the community resources (i.e. Supported Child Care information, Public Health, Child Development Centre, etc.) should be compiled by the staff and Local Advisory Committee as a separate list to be given to parents at referral to the Infant Development Program.

APPENDIX II-J ANNUAL REVIEW OF INFANT DEVELOPMENT PROGRAM STAFF

 If agency has different staff evaluation, add to this section

Instructions for Use

This evaluation is designed to assist Infant Development Program staff to improve his/her services to infants and families involved in the program. It is based on the IDP Job Description.

At regular intervals, commencing during the probationary period, the following Review will be completed. This Review should be a joint endeavour between the Infant Development Program staff person and his/her supervisor. Typically, the supervisor might be the Infant Development Program supervisor, the chairman of the Local Advisory Committee, member of the society's personnel committee or board/staff person of the sponsoring society. It is recommended that the two persons involved in the Review complete one form together by discussing each point listed and establishing realistic goals for improvement. Goals for improvement should be specific and dates for completion of goals should be established and reviewed at the next scheduled evaluation.

It is understood that this evaluation is primarily based on the subjective impressions of the people involved. However, the goals set through this exercise should, over time, provide a more objective framework for Evaluation.

Ratings are as follows:

4 Excellent
3 Well Done
2 Satisfactory
1 Needs Improvement
0 Unsatisfactory - must be re-evaluated within one month

Goals for improvement may be set for any one of the above ratings as "4" (Excellent) does not equal perfection. Materials or procedures which are useful in staff evaluation include:

- home visit records
- individual reports on children
- IDP / SCC Competencies
- parent/professional questionnaires
- observation of home visits and play groups

Annual Review of Infant Development Program Staff

Date Hired: _____

Name: _____ Date of Evaluation: _____

Title: _____ Supervisor: _____

Evaluation of Performance:

4 Excellent
3 Well Done
2 Satisfactory
1 Needs Improvement
0 Unsatisfactory — If a person scores Unsatisfactory in any category, this Review must be done again within one month.

A. Clinical Responsibilities

1. Supports the family in developing and maintaining loving relationships with their child.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

2. Assists families in planning and providing experiences in the home and community which will encourage the growth and development of the infant.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment:_____

_____

3. Records home visits, assesses the development of the child, and ensures that parents and relevant professionals are sent infant progress reports as desired by the family.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

4. Supports parents to obtain the best possible services for the child.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

5. Includes parents in any decision making process regarding the infant's education, social or health services.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

6. Assists the family in service coordination decisions as detailed in the Service Coordination (page 107) section of this Manual.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

7. Informs the family, when appropriate, of social and educational trends in service provision for persons with disabilities. Assists the family in understanding how inclusion may be put into daily practice.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

8. Loans appropriate books, video tapes and information to families which may assist them in understanding more about child development, a specific disabling condition and the impact a disability may have on normal growth and development and on family life.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

9. Loans developmentally- and individually-appropriate toys and assists the family to help the infant use the toys in an explorative way.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

10. Facilitates the introduction of the family to other parents for support and information if the family so desires

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

11. Informs the family of education, health and social opportunities such as playgroup, preschool or daycare available to their infant as he/she grows older.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

_____

Comment: _____

_____

12. Assists the family in the transition process between the IDP and any other services.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

B. Community Activities

1. Introduces the family to community resources which will be of benefit and assists the family to use these resources effectively.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

2. Assists the supervisor in setting up parent education and parent support programs and/or encouraging the development of community programs which will supplement in-home education (e.g. lectures, workshops, counselling groups).

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

3. Assists the supervisor in developing, when and where appropriate, group experiences for parents and infants.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

4. Assists the supervisor in keeping the community, including other professionals, informed of

the progress and benefits of the Infant Development Program, and assists the supervisor in facilitating inter-agency collaboration.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

5. Continues his/her own professional development (e.g. reading, course work, sharing information with other professionals in the field); attends staff meetings as they are set up by the supervisor, the Provincial and Regional Inservice.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

C. Administration (Applies to Supervisor and Sole-Charge)

1. Supervises Infant Development Consultant(s) including hiring, orientation, ongoing training, monitoring and evaluation of job related activities.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

2. Reviews all files quarterly.

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

3. Manages the case load and wait list for all children receiving service from the IDP

Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

4. Keeps records including monthly and annual statistics, central registry, and reports required by the sponsoring society, Provincial/Regional Advisors, and the Ministry for Children and Family Development.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

5. Orders and maintains up to date program resources, e.g. toys, videos, books, journals and equipment.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

6. Performs budget and long term planning in collaboration with the sponsoring society.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

7. Develops and maintains family-centered partnerships with parents, community professionals and agencies involved in service provision to young children and their families.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

8. Participates in developing inter-agency protocols for service co-ordination to ensure that professionals involved with the families work effectively together.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

9. Performs program evaluations which include parent and professional surveys, accreditation, the Mitchell Evaluation, and other evaluations determined by the sponsoring society.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

D. Staff Activities

1. Supervisor supports/ practices reflective supervision with staff
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

2. Participates in accountability processes as established by the Local Advisory Committee, the Sponsoring Society and the Provincial Steering Committee.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

3. Participates in staff meetings.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

4. Continues professional development and education
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

5. Participates in defining and filling program needs regarding supplies, assessment tools, films, resource books, etc.
Rating: _____

Goals for Improvement (steps to take to improve job):

_____

_____

Comment: _____

_____

E. General Characteristics

1. Punctual Rating: _____

2. Attendance Rating: _____

3. Enthusiastic regarding job Rating: _____

4. Innovative (projects/presentations/new methods of service delivery)
Rating: _____

5. Resourceful
   a. Planning Rating: _____

b. Spontaneously resourceful Rating: _____

6. Flexible Rating: _____

7. Responsible re maintenance of office and program supplies Rating: _____

8. Gives/receives directions Rating: _____

9. Works independently Rating: _____

10. Works well in a team/ supports team members in respectful way
Rating: _____

11. Personal skill development Rating: _____

12. Organizational/record keeping skills
a. Files maintained Rating: _____

b. Reports on time Rating: _____

c. Required statistics completed Rating: _____

13. Health related areas:
T.B. Checkup Date: _____

14. Professional Appearance Rating: _____

F. Unresolved personnel or staff safety issues:

_____

_____

G. Goals for the coming year

_____

_____

_____

_____ _____
Signature, Supervisor Signature, IDP Staff

STAFF HEALTH AND SAFETY

ORIENTATION CHECKLIST

Name: _____

Orientation Dates: _____

Please initial each topic after orientation

OFFICE

- ❑ tour of office _____
- ❑ location of fire exits, fire extinguishers, floor plans _____
- ❑ electric breaker box (location of emergency flashlights, candles) _____
- ❑ location and use of heaters and thermostats _____
- ❑ first aid supplies, their contents, and medical information _____
- ❑ library _____
- ❑ cleaning supplies _____
- ❑ phones, fax machine, computers, e-mail, and their use _____
- ❑ storage room _____
- ❑ garbage procedures, recycling procedures _____
- ❑ earthquake kit and supplies _____
- ❑ staff and emergency phone numbers _____
- ❑ toxic materials storage, storage safety issues _____
- ❑ kitchen and appliances _____
- ❑ use and location of keys (including emergency keys) _____
- ❑ smoking areas, smoking policy _____
- ❑ tour of main office and introductions to staff and management, other programs _____
- ❑ file cabinets, contents and uses _____
- ❑ office supplies, manuals, resource materials, information _____
- ❑ petty cash, how to record, when to use _____
- ❑ office opening and closing procedures _____

SPONSORING SOCIETY POLICIES AND PROCEDURES

- ❑ philosophy and mandate _____
- ❑ personnel policies, procedures & practices (confidentiality, ethics) _____
- ❑ abuse protocol, definitions of abuse and examples _____
- ❑ health, safety and wellness procedures and practices _____
- ❑ working alone/ working at home procedures _____
- ❑ fire/earthquake drills (monthly), smoke alarms (checked weekly), fire extinguishers (checked monthly), problems noted _____
- ❑ emergency procedures, evacuation plan, roles and responsibility of staff _____
- ❑ critical incident forms and criteria for when and how to use _____
- ❑ vehicle usage, insurance, and mileage forms _____

IDP POLICIES AND PROCEDURES

- ❑ IDP manual _____
- ❑ referrals and admissions policy and procedure discharge procedures _____
- ❑ communication book, boards _____
- ❑ petty cash _____
- ❑ lock-up procedure _____
- ❑ universal precautions, location of gloves, cleansers _____
- ❑ office maintenance _____

CASELOAD

- ❑ confidentiality _____
- ❑ home visits _____
- ❑ establishing rapport/relationship _____
- ❑ family centred care principles _____
- ❑ working with families from different cultures _____
- ❑ smoking _____
- ❑ working with other community professionals _____
- ❑ documentation _____
- ❑ assessments _____
- ❑ activity planning _____

STAFF

- ❑ job description _____
- ❑ supervision _____
- ❑ timesheets (where located, how to fill out, when / where to submit _____
- ❑ probationary period, benefits _____
- ❑ schedules _____
- ❑ requests for time off _____
- ❑ chain of command _____
- ❑ pay periods, overtime _____
- ❑ grievance procedures, harassment policy _____
- ❑ code of ethics, confidentiality _____
- ❑ discipline, termination policies _____
- ❑ appraisals _____
- ❑ collective agreement _____

Signed: _____

Staff Member: _____

Supervisor: _____

Date: _____

HEALTH ISSUES

TOY WASHING PROCEDURES

As consultants have regular and close contact with infants and families, it is important to maintain a high level of hygiene. Careful and consistent hand washing is the best protection again the spread of germs and illness. Follow universal precautions when dealing with spills or accidents.

1. Take toys for each home visit in separate bags. Do not share toys between homes.
2. After a home visit, disinfect the toys:
   Public Health recommends using a disinfectant of 1 part bleach to 9 parts water.
3. Mix and use within 24 hours
4. Air dry

This procedure should be used with all toys that come in contact with children, ie; playgroup toys etc.

SAFETY ISSUES

The nature of the work requires independence in working styles. It is important to notify office of your schedule.

- Utilize an in-out board
- Leave copy of your schedule with office staff.
- Notify office if you will be working at home or at another site.

See agency policy on working at home

WORKING ALONE (OFFICE)

1. Lock all exterior doors
2. Do not admit anyone to the office, other than those expected.
3. Turn off lights in reception areas so view of front door is clear
4. Park directly in front of building or in well lit area.
5. In the event of intruder call 911 or press alarm button.

When leaving building follow security procedures to set alarms. Visually check parking areas before unlocking door and exiting the building. When clear, have keys ready for quick access to your vehicle. Upon entering car, lock all doors.

TRAVEL

Let a designated person know when and where you will be travelling, and if possible, phone in to the office upon arrival and estimated time of departure. Someone should always know where you are and when to expect you back at the office. Use a cell phone to keep in touch when available. Travel, as much as possible in daylight hours. If making evening visits, arrange to call a designated person to alert as to arrival and departure times. Call again from home once you have arrived.

Set up a buddy system for out of town travel. Depending on the situation, have a sign in your car "Gone for Help", or stay in your car and roll down your window only to alert other driver that you need help. Refer to agency policy on vehicle use and insurance requirements.

HOME VISITING SAFETY

Staff safety while making home visits is an important concern. Each month, Infant Development Consultants visit hundreds of family homes. While few incidents involving risk to Infant Development Consultants have been reported, it is important to be cautious and alert, and to know how to avoid violent situations thereby ensuring your safety.

Your best protection is your own common sense. General precautions in visiting a home where safety issues are a concern include:

- Park your car in a way it cannot be blocked on your exit. Keep your car keys on your person.
- When you enter a home, know who is in the house. Ask to be introduced to all of the people in the house.
- Don't take your shoes off if you think you may have to leave quickly.
- Know where the nearest telephone is. It may be at a neighbour, nearby store or gas station. The use of a cell phone may be desirable.
- Go back into the home you were visiting if someone is loitering by your car when you start to leave.

Sometimes the circumstances of the moment may indicate risk. **Pay attention to your instincts.** If you feel uncomfortable, leave the area or home immediately. It may be helpful to have an excuse that you are comfortable using prepared for such a time.

Use extreme caution if faced with a domestic dispute or intoxicated or violent people. Leave immediately.

If you are threatened, leave immediately.

BEFORE VISITING

If you have concerns about safety before visiting a home or an area, consider the following:

- Arrange to meet the family at a neutral site such as a park or other public place.
- Have a second staff member or other agency representative known to the family accompany you on the home visit.
- Establish an informal buddy system with your family, friends or co-workers. If you are visiting a high risk area, tell your buddy your planned destination and time of return. Arrange a pre-visit and post-visit call to your buddy. You may want to have your colleague phone you at the family's home 10-15 minutes after your estimated time of arrival.

Should a specific health or safety issue arise, consult with your supervisor or Regional Advisor. An example of this is winter travel in isolated areas.

CONFLICTS OF INTEREST

Employees will not be allowed to solicit, obtain, accept, or retain any personal benefit from any supplier, vendor, client, individual or organization doing or seeking business with the sponsoring agency. As used here, personal benefit means a gift, gratuity, favour, service, compensation in any form, discount, special treatment, or anything of monetary value. The following may serve as exceptions, but employees should consult with a supervisor when circumstances are questionable.

- The purchase of business/professional meeting meals;
- Reasonable gifts offered during the holiday season where rejection would damage the spirit in which they were given.

It must be noted that, if an employee at any time feels that they may be in a conflict of interest, it should be

discussed with a supervisor. These situations will be considered on a case-by-case basis by the Executive Director or, should the Executive Director be in conflict, by the Executive Committee of the Board.

GENERAL GUIDELINES FOR CONFLICT RESOLUTION

Any person involved with an Infant Development Program and involved in a conflict may find these guidelines helpful: parents, staff, other agency staff, local advisory committees, boards, other community agencies.

When a conflict arises:

1. If appropriate, address the concerns to the person you are having the conflict with.
2. Determine if the IDP sponsoring society has a protocol for resolving conflicts.
3. If you are a member of a union, the union will have a protocol or grievance procedure if the conflict relates to a personnel issue.
4. A typical chain to follow is: discuss the conflict with a) supervisor b) local advisory committee c) executive director and/or board. At any point in time, you may get helpful informal suggestions from your fellow staff, supervisor, regional advisor, provincial advisor, union representative, B.C. Association of Infant Development Consultants (BCAIDC).

If the conflict is unresolved:

5. Formal request for active involvement of Regional Advisor, Provincial Advisor and Provincial Steering Committee, BCAIDC, Union, or the Community Social Services Employers Association.

If the conflict remains unresolved:

6. These public services may be able to offer assistance: Ministry for Children and Family Development, Labour Relations Board, Community Social Services Employers Association, Employment Standards Branch, Information and Privacy Division, Office of the Ombudsman.

REPORT INCIDENTS

Call the police and report any suspicious or unusual circumstances or incidents. Report all safety-related incidents as soon as possible to your supervisor and Regional Advisor.

INCIDENT REPORT FORM

 add a copy of agency incident / accident form on letterhead

Program Information (Please attach separate sheet if more space required)
Name of Program:

Address: Telephone:

Persons Involved (Please attach separate sheet if more space required)

Details of Incident (Please attach separate sheet if more space required)

Date and time of incident:

Witnesses

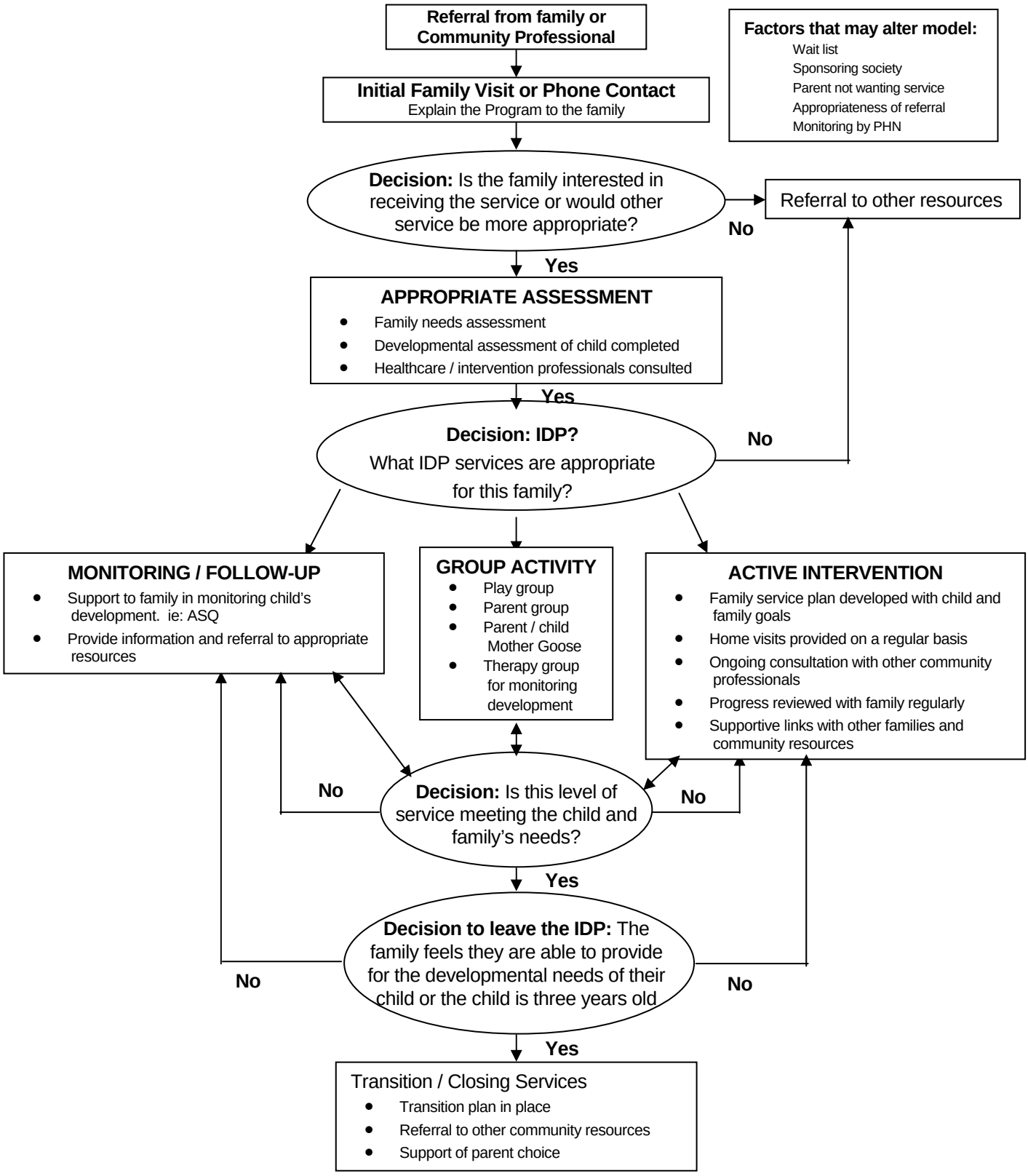
Action Taken (Please attach separate sheet if more space required)

Signature of staff person reporting _____

Signature of Program Supervisor (or person to whom you report): _____

SECTION III PROGRAM OPERATION

MODEL OF SERVICE FOR IDP OF BC



INFANT DEVELOPMENT CASELOAD

All children have the right to grow up in a safe and loving family with access to a full range of social, educational, and community experiences. It is the overall intent of the Infant Development Program to support families so that these rights may be realized. Central to this is assisting families in developing and maintaining loving relationships with their child.
The family has thus become the primary focus of services for the Infant Development program and the home is the centre around which programming is built. While there is no question about the necessity of good diagnostic and medical treatment, genetic counselling, and a myriad of other treatment agents, the focus on this program is to provide early support and intervention in the home through and with the family. The aims of the program are to help parents make optimum use of available services, to enlarge their knowledge of those factors pertinent to the overall growth and development of their child, and to learn skills, which will enable them to encourage the development of their child.

CRITERIA FOR ELIGIBILITY

The Infant Development Program will accept children into the active caseload (see glossary) and will provide regular home visits, and other specified services if the following criteria for eligibility are met. Given extraordinary circumstances relating to geography or the individual needs of a child or family, these criteria may be modified. Waiting lists may be established if the caseload exceeds 15-25 families per full time IDP Consultant. The recommended ratio for IDPs in BC is 15-25 families per full time IDP Consultant.

- infant referred is aged birth to three years (in some circumstances children may be followed up to 5 years of age *)*
- infant delayed in one or more skill areas or infant at risk for developmental delay
- family agree to participate
- the IDP is the most appropriate service available
- family lives within geographic boundaries for regular home visits (exceptions may be made in certain circumstances)

PRIORITIES FOR SERVICE

If referrals meeting the above criteria exceed a caseload that can be effectively managed, it is recommended that the Case Review Committee and the Local Advisory Committee consider the following additional factors in establishing priorities for service.

- degree of developmental delay or disability
- age of child
- family situation
- geographic location of the home
- other agency involvement

Each of these factors should be considered in light of the area being served by the Infant Development Program, as each program faces unique circumstances related to:

- available services and professionals
- population distribution
- geography and climate

Accreditation requires that each program have a written plan that delineates how referrals and waitlists are managed and how families are informed of these processes.

PRIORITIZED WAITING LIST

A waiting list may need to be prioritized to ensure that families most in need of a service receive it first.

Waitlist Priority Rating:
Consider the following

1. Transfer from another IDP where family was receiving service.
2. Significant visual impairment
3. Child's condition would deteriorate without intervention, (ie some neurological conditions, very low birth weight, premature babies with medical complications etc)
4. Child has a diagnosis (Down Syndrome, Spina Bifida, autism)
5. Family has a high level of concern and/or need for information regarding the child's delay.
6. Child showing significant delay in one or more skill area.
7. Child at risk for delay. (pre-maturity but doing well, possible prenatal exposure to drugs/alcohol, small for gestational age)

If a waiting list is established by a program to maintain a reasonable ratio of families/consultant, it is strongly recommended that the staff and Local Advisory Committee develop interim support services for families until such time as regular home visits can commence.

These services may include:

- monthly drop in to screen child development with therapist and IDP consultant
- parent-to-parent projects or a regional parent from the Family Resource Institute
- packages of information relating to developmental guidance
- access to books and information relating to disabilities
- invitations to attend parent meetings or workshops on child development, or mom and tot groups
- referral to other agencies that may provide support

It is recommended that a form letter be drafted which will be sent to families on a waiting list, a copy of which should be sent to the referral source. This letter should include:

- description of the Infant Development Program
- explanation for delay in accepting the referral for regular home visits
- approximate date in the future that the family may expect to receive regular home visits
- description of available interim supports in the community (as above)
- address of the IDP for the parent who wishes to maintain communication in regards to services for their child

Parents are notified of discharge from waitlist when they are accepted into the caseload of a consultant.

See Waitlist Sample Letter (page 171)

EXCEPTIONS TO A WAITING LIST

The Local Advisory Committee may decide that some infants (e.g. infants with a newly diagnosed disability) should receive direct service from Infant Development Program staff, regardless of the caseload size, or existence of a waiting list. It is recommended that the staff and Case Review Committee review the existing caseload to determine which families could receive fewer or, perhaps group visits, to accommodate infants who should be accepted regardless of caseload size.

Families who are involved in an Infant Development Program who move to another community should be informed well in advance of their move (if possible) if there is a waiting list for the Infant Development Program in that community. They should be placed on that waiting list as soon as possible if they wish continued IDP services. Some programs have agreements to immediately accept families who have previously been with an IDP into the caseload when they move.

REFERRAL SYSTEM TO INFANT DEVELOPMENT PROGRAM

1. Open Referral

- referrals are directed to program supervisor by letter, fax or phone call
- referrals accepted from parents and professionals
- a referral will not be accepted unless the family are aware of the referral and accepting of the referral. Generally the referral source has talked to the family about the program. If not, this is requested by Infant Development Program supervisor prior to contacting the family
- Referral Form (page 133) is started

2. Initial Contact with Family

- if possible or practical, the Infant Development Program Consultant who will make the initial visit (and continue with the family) telephones the family, introduces him/herself and describes program, including criteria for eligibility
- visit arranged by Infant Development Program Consultant at convenient time if family wish to participate

3. Initial Visit (see section on home visiting)

- Referral Form completed by Consultant and family
- discussion of program takes place
- discussion/assessment of priorities and needs of family
- informal or formal assessment of infant
- program plan is started
- direction to other community services may take place
- future visiting schedule is arranged
- leave parent copies of consent forms
- leave parent information package
- note on intake/ referral form what information was left

The parent information package will contain: a program overview, information on community services and programs such as Playgroup, clients rights and responsibilities, and complaint procedures.

The Parent Information Package will be unique to each program. For your reference, see Appendix IV-A **Parent Orientation Package** (page 224); Appendix IV-B **Rights and Responsibilities** (page 230); Appendix IV-C **Policy on Colds and Flu** (page 232); and Appendix IV-E **Partnership Agreement** (page 236).

It is important to be aware of the amount of information given to the family. Do not overwhelm the family with information. Ensure that written material is at an appropriate literacy level in the family's first language or provide an interpreter. Truly informed consent is when families understand the material.

4. Following Initial Visit

- Infant Development Program Consultant contacts physician by phone and/or form letter
- contacts referral source and other involved professionals by phone and/or form letter
- discussion at Case Review Committee

CASE REVIEW COMMITTEE

It is recommended that the Society and the Local Advisory Committee establish a small sub-committee comprised of professionals involved in the Infant Development Program to review the caseload on a regular basis. This committee will act as a back-up to staff in decisions regarding services to infants and their families. The Committee may also make recommendations to the Local Advisory Committee regarding the Infant Development Program services and/or caseload. Programs that have established a Case Review Committee have found it convenient to set Case Review meetings to precede or to follow Local Advisory Committee meetings as membership overlaps. This cuts down on time involved.

Members of the Case Review Committee need to be identified on the consent form so families are aware of who will be reviewing the files.

MEMBERSHIP

Membership on the Case Review Committee may include one or more of the following professionals:

- Infant Development Program Consultant
- Physician
- Public Health Nurse
- Consulting therapist to Infant Development Program (physiotherapist, occupational therapist, or speech and language pathologist)
- M.C.F.D. social worker
- Mental health counsellor
- Family support worker

Parents of the child being reviewed or other community professionals may be invited to participate in a discussion when additional input is needed. This committee is not intended to replace a team meeting for child and family.

TERMS OF REFERENCE FOR THE CASE REVIEW COMMITTEE

1. To review caseload and new referrals to the Infant Development Program
2. To make recommendations to the Local Advisory Committee regarding priorities for service
3. To assist in referring infants to more appropriate resources, when applicable
4. To prevent inappropriate use of Infant Development Program services
5. To make recommendations to the Local Advisory Committee regarding medical information and medical referrals, assessments or follow-up

NOTES ON THE TERMS OF REFERENCE FOR THE CASE REVIEW COMMITTEE

1. To Review Caseload and New Referrals to Infant Development Program

Present Caseload: Infants receiving service from the Infant Development Program should be reviewed by this committee bi-annually. This should coincide with the bi-annual report on the infant. During this review the Infant Development Program Consultant involved with the family should present the following information to the committee:

- developmental status of infant
- goals set with family for infant
- agencies presently involved
- follow-up plans including referral to other agencies
- problems encountered in providing or seeking service for infant and family

New Referrals: Infants referred to the Infant Development Program subsequent to the last Case Review Committee meeting should be presented. Generally, these infants will be in one of the following categories. Guidelines for information-sharing related to these categories are as follows:

a) Infants considered for acceptance into active caseload

These infants will have received at least one home visit by the Infant Development Program staff. Intake form will be completed. Information gathered during home visit and from referring agency and / or agencies involved will demonstrate that:

- infant meets criteria for eligibility to Infant Development Program and the family wish involvement with the program
- developmental status to include information on development for input from consulting therapist

b) Infants considered for acceptance into follow-up caseload

Depending on the geographic location of family home and other factors, these infants may or may not be visited prior to review by the committee. Follow-up caseload generally consists of infants who were previously on active caseload and now do not require regular home visits and infants who do, but due to geography or caseload size, are not receiving regular home visits. Information shared about these infants should demonstrate that:

- infant meets criteria for eligibility in a follow-up caseload and family wishes to be on follow up caseload
- developmental status to include information on development for input from consulting therapist

c) Monitoring

IDPs may monitor the development of a child if there is no more appropriate agency (e.g. Public Health) to do this. Monitoring is done to ensure early referral to intervention (e.g. IDP or therapy) if a delay in development is determined. Monitoring will involve the use of a standardized screening tool like the ASQ. This will be administered by the parent at routine intervals. Some programs offer playgroups or other services that may be accessed by the family during the period the child's development is monitored. If developmental concerns arise the child will be moved to active caseload in a timely manner. A decision should also be made in a timely manner to end monitoring if development is proceeding normally. Some families may wish to continue to use the ASQ in their own interests and copies of the questionnaire may be left with the family. Certainly, if in the future concerns arise the family may refer themselves back to the IDP for support.

Families should be alerted to the fact that some developmental problems do not emerge in infancy and may only be captured when children are over age three. Some learning disabilities are difficult to measure until the child is school age. Therefore, parents of children at risk should keep a close eye on their child's development as they grow older. Early discharge from the IDP does not mean later problems may not emerge. The earlier these problems are detected generally the more effective the intervention and positive outcome.

d) Infants referred but not eligible for service

Home visits may or may not take place prior to discussion by Case Review Committee. Information shared should include:

- reason why infant did not meet criteria for eligibility (e.g. over age, parent does not wish service, etc.)
- referral to other agency, if applicable
- if inappropriate referral from an agency or individual, discussion of ways to best inform agency of Infant Development Program policies regarding criteria for eligibility

e) Infants placed on waiting list

These infants should be reviewed regularly to ensure:

- placement in active caseload takes place as soon as possible
- interim supports are available to family
- letter has been sent or phone call made to parent and referral source
- see notes about waitlist criteria.

2. To make recommendations to the local advisory committee regarding priorities for service

The Case Review Committee should be familiar with IDP Caseload Criteria for Eligibility and use this to establish priorities for service that are appropriate to the area served by the Infant Development Program.

The procedures involved in setting up a Waiting List should be developed by the Case Review Committee and presented to the Local Advisory Committee for approval.

3. To assist in referring infants to more appropriate resources when applicable

Concerns in this area should be brought to the Case Review Committee for discussion and, if recommendations are made, presented to the Local Advisory Committee for discussion and, if appropriate, forwarded to the Board. Examples of areas which may present problems:

- unavailability of paediatric therapy services
- lack of pre-school programs for children

4. To prevent inappropriate use of Infant Development Program services

Families experiencing severe economic or social problems may need a range of services of a more intensive nature than can be supplied by an Infant Development Program. Some referral agencies to an Infant Development Program may not be aware that the program cannot provide intensive intervention, or agencies may feel that because the Infant Development Program is involved, other services are not needed by the family. The Case Review Committee should provide assistance to staff in determining routes to acquire additional supports for families when needed. In addition, the Case Review Committee may assist staff in determining the role of the Infant Development Program when other agencies are involved (e.g. consultant role rather than direct service role). It is critical that Infant Development Program Consultants inform the referral source in writing of the following:

- family needs more intensive services than we can provide
- family not available for home visits
- family cannot be contacted

Any family suspected of abuse or neglect of their child must, by law, be reported to the Ministry for Children and Family Development.

5. To make recommendations to the Local Advisory Committee regarding medical information and medical referrals, assessments or follow-up

Infant Development Program staff should bring forward for discussion with the Case Review Committee concerns regarding the medical care of infants receiving service from the Infant Development Program. These concerns may range from availability of medical services to difficulties in encouraging referral to specialized services, such as physiotherapy or diagnostic work-ups. A form letter for parents outlining available therapy services in the program area should be drafted by this committee and presented to the Local Advisory Committee for approval. The Case Review Committee may review up-to-date articles relating to the medical care of infants with disabilities and recommend the circulation of appropriate articles to the medical community.

SERVICE COORDINATION

In most families 'service coordination' is a natural function of the parental role. However, a more formal approach to service coordination may be beneficial for some families, particularly when more than one agency is actively involved with a child. The Infant Development Program (IDP) strives to co-ordinate services with families based on a commitment to family-centred care. This commitment emphasizes strengthening the family's capabilities to expand their capacity to negotiate for, to obtain and to co-ordinate resources which meet their unique needs.

When a more formal approach to service coordination is beneficial, families who wish to assume part or all of this role will be supported in this by IDP consultants. Some families may wish an IDP consultant to assume this role. In some situations, another professional in the community may be the most appropriate person to provide this service. The person assuming this role, whether parent, IDP Consultant or community professional, should be acknowledged and supported in this by other professionals involved with the child and family.

In some communities, written agreements between agencies may be necessary to ensure staff work as effectively as possible in providing services to families. When disagreements as to role or function arise, the Case Review Committee and/or the Local Advisory Committee to the IDP should be requested to provide direction and assistance. If differences cannot be resolved at a local level, the Regional Advisor to the IDP and/or the Provincial Advisor and Provincial Steering Committee may be requested to assist.

Service coordination for families in IDPs will vary considerably for each family. However, if an IDP consultant is coordinating services on behalf of a family the following guidelines will be followed:

1. **Provide opportunities** for families to identify and prioritize their needs and the needs of their child. If a team meeting is planned, this is done with a family prior to the team meeting in preparation for their sharing this information **during** the meeting. Respect for the family lifestyle, language, culture and other individual differences will be maintained.

2. **Periodically meet** with families to work to:
   - discuss changes in family situation, etc. to document areas for consideration during subsequent team meetings.
   - anticipate changes in service provision (e.g. transition to other program such as preschool).

3. **Organize team meetings** every 6 months or when deemed as needed by the family and IDP consultant with all major service providers determined by the family. The purpose of these meetings is to:
   - discuss family's needs and priorities
   - review long-term goals (short term objectives when appropriate)
   - share assessment results.
   - problem solve around services/resources/equipment, etc.
   - The information shared and decisions made at these meetings must be documented and distributed to involved professionals and may form the basis of an individual family service plan (I.F.S.P.).

4. **Provide families with the necessary information** so that **they** may:
   - make informed decisions about their child's life (i.e., preschool, daycare, recreation, therapy).
   - take the necessary action to meet needs (i.e., arrange physio services; discuss referral to a specialist, etc.).

5. **Assist families to gain skills at negotiating** with service agencies:
   - develop/enhance interpersonal communication skills.
   - call meetings, take minutes (or ensure someone else takes them).
   - clarify if unsure.
   - state needs clearly, identify why they need what they need.
   - learn appeal processes.
   - locate and use an advocate (other parent or professional who can help in negotiation process).

6. **Accept and support decisions made by families** and encourage this acceptance and support by all team members.

7. **Assist families in interpreting assessment results** from a variety of sources (PT, OT, speech and language pathologist, psychologist, etc.)prior to the team meeting. During team meetings when the necessary professionals can attend, this assessment information from a variety of sources can be incorporated into the family goal plan.

8. **Act as a central resource person/trouble shooter** for family members and team members. Once a family goal/service plan has been developed, ongoing responsibilities include:
   - problem-solving **with** a family if services break down.
   - problem-solving **with** a team member if a concern regarding follow-up arises.

   Therefore, if a family member or service provider encounters a problem with any aspect of the plan for the child/family, the IDP Consultant should be informed.

9. **Document any calls, problems, action taken between team meetings and bring for discussion at the subsequent team meeting.**

10. **When the child approaches age 3, to assist families to identify a person to function as a service coordinator when the IDP is no longer involved with the family.**

Service coordination is a time-consuming but **ESSENTIAL** function in the lives of families who are surrounded by a variety of service providers. The success of the "team approach" and empowerment model of service coordination is dependent upon the extent to which **ALL** members are committed to sharing their skills and making it work.

OBTAINING AND WORKING WITH THERAPY SERVICES FOR INFANT DEVELOPMENT PROGRAMS IN BC

One role of IDP staff is to screen children in Infant Development Programs for problems which may be treated by therapists. Through consultation with parents and family physician, IDP staff may refer children as soon as possible to needed and available therapy services. Most professionals working with families with very young children recognize the need for families to live lives as normally as possible. Therapists and IDP staff therefore collaborate on behalf of families they serve to avoid overwhelming families and increasing stresses on them. Recent research (Rossetti, 1994) and our own findings in B.C. (UBC Summer Institute 1987) supports a trans-disciplinary approach to intervention with young children and their families.

Therefore, IDP staff in consultation with therapists in each community should determine how best limited resources should be used. Issues that should be examined include gaps in service for preschool and school age children and possible duplication of service. For example, it may be more useful for one therapist rather than three or four to serve one family or sit as a consultant on the IDP case review committee.

THERAPY SERVICES

There are three types of therapy services available to some families of infants on the Infant Development Program in B.C. These are physiotherapy, occupational therapy and speech therapy and they have defined their roles in the following section.

Physiotherapists assess and treat children with physical, orthopedic and/or neurological problems. The aim is to encourage normal gross motor development and to maximize functional independence through specific therapeutic activities.

Occupational therapists assess and treat children who require specific assistance in the areas of fine motor, sensorimotor, self-care, visual perceptual, cognitive, and/or oral-motor skills. Treatment is directed towards enhancing functional abilities, building skills and/or adapting the environment so that the child reaches the fullest level of independence in self-care, leisure or play.

Speech pathologists diagnose and treat children who require additional assistance in the areas of feeding, pre-language development, language, articulation, social interaction, voice and fluency, oral-motor skills. Individualized programs are designed to improve functional communication.

INFANTS WITH THERAPY NEEDS IN INFANT DEVELOPMENT PROGRAMS

There are four levels of therapy services available for infants referred to Infant Development Programs. These levels are: review and/or assessment, monitoring, consultation and direct therapy.

a) Review and/or Assessment Services

Therapy opinions should be sought for all children referred to an Infant Development Program. This may take place through the Case Review Committee, group and/or home visits. In consultation with the parent, physician and Infant Development Consultant (IDC), the therapist will recommend:

- no therapy
- consultation
- monitoring with the IDP consultant
- direct therapy

b) Consultation*

For infants with a delay or disability who do not require intensive therapy (e.g. general delay, Down Syndrome) the consulting therapist(s) to the Infant Development Program, or other qualified therapists available, should review the development of each infant on a regular basis. This should include a review of the current program with suggestions to the family and Infant Development Consultant of activities designed to encourage normal development. Activities should include consideration of other developmental areas and the ability and/or time required for the family to follow a program.

c) Monitoring*

Use of monitoring requires that the therapist conduct an assessment to identify the strengths and changing needs of the child or family. The therapist designs an intervention plan to meet individual needs and remains responsible for the plan. The parent and Infant Development Consultant are trained by the therapist to carry out the plan, so that procedures will be implemented on a consistent basis and have greater chance for generalization. The therapist is responsible for remaining in regular contact with the family so that necessary alterations in the program can be implemented in a timely manner.

d) Direct Therapy*

Direct therapy is required for some children (e.g. cerebral palsy). The focus of direct therapy is to meet the child's individualized needs through very specialized therapeutic strategies and is carried out by the therapist working directly with one child or a small group of children. The therapist monitors changes that occur and alters the treatment interventions very quickly to accommodate for changes that occur.

*Based on Ministry of Health Definitions.

SERVICE DEFINITIONS

The following Service Definitions are taken from the Ministry of Health, Early Intervention DRIS Release Notes, August 1995

Consultation

Consultation is a form of service provision in which the therapist is using his or her expertise to enable another person to address issues, needs and desired outcomes identified by that person. The consultee rather than the therapist is responsible for the outcomes of the individual in the consultation model. The therapist is responsible for the collaborative efforts with the adult who is carrying out the program or providing care to the client. A collaborative style of consultation acknowledges the specialized expertise of both the consultant and the consultee.

Monitoring Services

Use of monitoring for service provision requires that the therapist conduct an assessment to identify the strengths and changing needs of the individual client (child or family). The therapist designs an intervention plan to meet individual needs and remains responsible for the plan. Another person within the client's natural environment is trained by the therapist to carry out the plan, so that procedures will be implemented on a consistent basis and therefore, have greater chance for generalization. The therapist initiates and is responsible for remaining in regular contact with the person who carries out the monitored program, so that necessary alterations in the program can be implemented in a timely manner.

Direct Therapy

Therapy refers to those intervention activities that are individually designed for a client, and are carried out by the therapist and one client or the therapist and a small group of clients. The focus of direct therapy is to meet client's individualized needs through very specialized therapeutic strategies. The therapist is required to monitor changes that occur and alter the treatment intervention very quickly to accommodate for the changes that occur.

LOCATING THERAPY SERVICES

Infant Development Program Supervisors and the Local Advisory Committee will determine what therapy services for children are available in the geographic area served by the Infant Development Program. It is recommended that the program request assistance in this from therapists, preferably with paediatric experience, presently employed in the program area. If the Infant Development Program operates in an area with a Child Development Centre or other paediatric treatment facility, a representative from that facility should be requested to participate in these discussions and decisions. Other community agencies which may employ therapists who could provide information are hospitals and health units. In determining what therapy may be available to the Infant Development Program these factors should be considered:

- therapy needs of infants in Infant Development Program, periodic and ongoing
- geographic area served by therapy services
- home-based and/or centre-based services
- specialized or generalist approach
- cost - how services are funded
- referral procedures for assessment and for treatment
- average time between referral, consultation and/or treatment
- maximum number of infants that may access service from agency (e.g. do they or might they have a waiting list)

The range of therapy services available to infants in the Infant Development Program should be described in writing and reviewed by the Local Advisory Committee regularly, as services and caseload needs may change over time. This function may be delegated to the Case Review Committee. Up-to-date descriptions of appropriate therapy services should be available to parents/guardians of infants on the Infant Development Program caseload who are in need of follow-up or direct treatment from a physiotherapist, occupational therapist or speech pathologist.

It is recommended that following a review of therapy services, the Local Advisory Committee request a therapist, preferably with paediatric experience, to function as a consultant to the Infant Development Program.

THERAPY CONSULTANTS TO THE INFANT DEVELOPMENT PROGRAM

This is a relationship which is developed in consultation with the therapists, their employers, the Infant Development Program Supervisor and the Local Advisory Committee. Generally, Infant Development Programs do not have funds available to purchase consultative services such as these from other agencies. However, most agencies employing therapists to work with children or with a population that includes children, acknowledge that the therapy needs of infants in Infant Development Programs are within their mandated responsibility, have recognized the benefits of close partnership and are willing to provide services.

Generally, a therapy consultant is available to an Infant Development Program to:

- sit as a regular or ex-officio member of the Local Advisory Committee
- sit as a member of the Case Review Committee
- consult regarding infants referred to Infant Development Program through participation on Case Review Committee, home and/or group visits
- participate with the parents, physician and Infant Development Program Consultant in decisions regarding the therapy needs of the infant
- collaboratively develop and/or supervise the physio, occupational or speech programs for infants

WORKING WITH THERAPY CONSULTANTS

a) During the course of the initial home visit by the Infant Development Consultant the family will be informed that consulting therapists work closely with the program and that these services are available to all infants. It is recommended that these services and the rationale for these services be described in a low-key manner, and presented during the course of the initial home visit so that the family is not unnecessarily concerned if and when the therapists become involved. This is particularly important if the infant does not have, at that time, a medically diagnosed disability. Written information on the IDP prepared for parents should also describe therapy services offered in coordination with the program.

b) As soon as possible after referral to an Infant Development Program, the infant will be reviewed to determine the need for therapy services. This review will involve one or more of the following procedures:

- infants will be discussed at the Case Review Committee
- home visit with a therapy consultant
- playgroup visit by a therapy consultant

c) Initial Consultation: It is preferable that the therapist see infants jointly with the Infant Development Consultant particularly for an initial consultation, under the sponsorship of the Infant Development Program, rather than requiring referral to another agency. Reasons for this include:

- does not generate unnecessary parental anxiety
- prevents possible duplication of services
- reduces confusion for family

An open referral can be made directly to a physiotherapist, occupational therapist or speech and language pathologist. However the Infant Development Supervisor should confirm referral procedures with each agency providing therapy services in the Infant Development Program's geographic area.

With parental permission, the physician should be kept up-to-date in writing on the development of the infant and the programs developed by the therapists.

d) Initial assessments or ongoing consultation through home/group visits by the consulting therapists should be coordinated with visits by the Infant Development Consultant for these reasons (may include joint visits as appropriate):

- Infant Development Consultant generally has established a rapport with the family
- Reduces confusion for the family
- During joint visits, the Infant Development Consultant can record suggestions made by the therapist for his/her own records and for the parents
- Infant Development Consultants can learn the proper way to carry out therapy suggestions during the course of home visits and assist parents to incorporate suggestions into routine care of the infant and in programming in other skill areas (e.g. positioning for cognitive tasks)

It is assumed that the therapist will keep his/her own treatment records for reports to the parents, physicians or other medical assessment centres. On the home program the therapist's name should appear to establish under whose authority the suggestions were given.

e) When an infant is referred for ongoing therapy, it is recommended that the Infant Development Consultant occasionally attend therapy sessions if the infant continues to receive service from the Infant Development Program. This will enable the Infant Development Consultant to:

- learn skills that the therapist wishes to demonstrate that should take place in the home
- support parent and facilitate service coordination

THERAPISTS EMPLOYED AS INFANT DEVELOPMENT CONSULTANTS

Infant Development Consultants function as generalists. The procedures outlined in this section should be followed by Infant Development Programs which have hired therapists as IDP Consultants. The Case Review Committee and Local Advisory Committee may modify these procedures if necessary but roles should be clearly understood by all involved. It is necessary that the Infant Development Program be seen as a generalist approach to early intervention. Therefore, if staff changes occur, and a professional from another discipline is hired, program changes will be minimal.

However, it may well be in the interests of some infants and families served by an Infant Development Program with a therapist as staff, to utilize the specialized expertise of the staff person at the Committee level and at an individual level with the children. This may be of particular importance if the program is serving an area with limited specialized services. The Case Review Committee and Local Advisory Committee should consider these issues in relation to their program area and present and future staffing patterns.

WORKING WITH FAMILY SUPPORT WORKERS

The position of Family Support Worker was established by the Ministry of Health - Speech, Language and Early Intervention Program to work in Child Development Centres. The role of the Family Support Worker can be three fold: a resource for families and other professionals such as Infant Development Consultants, a source of support working directly with a family, and/or an advocate for the family and child.

Family Support Workers can be invaluable resources for Infant Development Consultants, especially those working in sole charge positions. Family Support Workers may provide or assist the Infant Development Consultant in providing opportunities for families to network either individually or in parent groups, run educational workshops, make referrals to other services or agencies. For families with complex needs that go beyond the skills or mandate of the Infant Development Consultant, a Family Support Worker may be directly involved in one-to-one counselling with the family.

Referral to a Family Support Worker is open and can be made by the family themselves, the Infant Development Consultant, or any other concerned person.

Upon discharge from the Infant Development Program, a family may be given the name of the Family Support Worker as a primary contact for support, service coordination, and resources. Often families leaving the Infant Development Program have expressed feelings of "being lost or abandoned" without an adequate level of support. They often "don't know who to turn to". Family Support Workers certainly are in a position to fill this need for families in the communities fortunate enough to have a person in this position. Joint visits with the Family Support Worker and the Infant Development Consultant may help the family make an easier transition from the Infant Development Program to other programs.

Note: Family Support Workers funded through the Ministry of Health are described above. Family Support Workers funded through the Ministry for Children and Family Development usually have a more direct, hands-on role working with the child.

WORKING WITH AN INTERPRETER

Having a family visit through the use of an interpreter introduces an added dimension of complexity to building relationship to family. The following suggestions may help when working with families.

Guidelines for using interpreters to enhance cross–cultural communication

1. The role of the interpreter is to make communication possible between two or more people who do not share a common language.

2. It is not the role of the interpreter to offer advice, nor to act as an advocate for either side.

3. Consultants should retain the responsibility for the tasks they normally perform and not delegate those tasks to the interpreter.

How to choose an interpreter

1. Ideally an interpreter should be someone who is:

   - trained in cross cultural interpretation
   - trained in the health care field
   - proficient in the languages of both the client and the health care professional and
   - able to understand and respect both their cultures

   These interpreters are ideal because they not only translate the interaction but also bridge the cultural gap.

2. In the absence of a trained interpreter, use a volunteer with training in medical terminology, an understanding of the significance of a particular health matter they will be translating and an understanding of the importance of confidentiality.

3. Avoid relying on hospital personnel who are bilingual if they have not had some training as an interpreter.

4. Be cautious about the use of family members-especially those of a different age or sex from the client. Clients are often embarrassed to discuss intimate matters with members of the opposite sex or with members older or younger members of their families. Family members may wish to censor what is said to shield the parent or keep information from the parent.

5. Be sensitive to the parents' right to privacy and their choice of who should act as an interpreter. Often there are problems when the interpreter is of a different social class, educational level, age or sex. There can also be concerns about confidentiality if the interpreter is from the same community as the family.

How to work with an interpreter.

1. Meet regularly with the interpreter in order to keep communications open and facilitate an understanding of the goals and purpose of the visit. Certainly you should meet with the interpreter before you meet with the family.

2. Encourage the interpreter to meet with the family before the visit to find out information about the families educational level and their attitudes about the health and health care. This information can aid the interpreter in the depth and type of information and explanation that will be needed.

3. Speak in short units of speech, not long involved sentences or paragraphs. Avoid long ,complex discussions of several topics in a single visit.

4. Avoid technical terminology, abbreviations and professional jargon.

5. Avoid colloquialisms, abstractions, idiomatic expressions and slang, similes and metaphors.

6. Encourage the interpreter to translate the client's own words as much as possible rather than paraphrasing or "polishing" it into professional jargon. This gives a better sense of the family's concept of what is going on, emotional state, and other important information.

7. Encourage the interpreter to refrain from inserting his or her own ideas or interpretations, or omitting information.

8. To check on the client's understanding and accuracy of the translation, ask the parent to repeat instructions or whatever has been communicated in their own words, with the translator facilitating.

9. During the visit, look at and speak directly to the parent, not the interpreter.

10. Listen to the parent and watch their nonverbal communication. Often you can learn a lot regarding the affective aspects of the parent response by observing facial expressions, voice intonations and body movements.

11. Be patient. An interpreted visit takes longer. Careful interpretation often requires that the interpreter use long explanatory phrases.

12. Even if you are using an interpreter, there are ways you can become more actively involved in the communication process.

    - Learn proper forms of address in the family's language. Use of these will convey respect for the family and demonstrates your willingness to learn about their culture.

    - Learn basic words and sentences of the family's language. Become familiar with special terminology used by the family. Even though you cannot speak well enough to communicate directly, the more you understand, the greater chance you will pick up on the misinterpretations and misunderstandings in the exchange.

- Use a positive tone of voice that conveys your interest in the family. Never be condescending, judgmental, or patronizing.

- Repeat important information more than once. Always give the reason or purpose for a treatment.

- Always supply materials written in the language understood by the family.

Non-verbal communication

Much of what is communicated is not verbalized but conveyed through facial expressions and body movements that are specific to each culture. It is important to understand the cross-cultural variations in order to avoid misunderstandings and unintentional offenses.

Silence: some cultures are quite comfortable with long periods of silence while others consider it inappropriate to speak before the other person has finished talking. Learn about the appropriate use of pauses or interruptions in the family.

Distance: some cultures are comfortable with close body space, while others are more comfortable at greater distance. In general, Anglo Americans prefer to be about one arms length away from another person while Hispanics prefer closer proximity and Asians prefer greater distance. Give your family the choice by inviting them to have a seat wherever they like.

Eye contact: some cultures advise their members to look people straight in the eye while others consider it disrespectful or a sign of hostility or impoliteness. Observe the family when talking and listening to get cues regarding the appropriateness of eye contact.

Emotional expressiveness varies greatly from one culture to another. Some cultures value stoicism while others encourage open expression of such emotions as pain, joy and sorrow. Some may smile or laugh to mask other emotions.

Body movements take on a different meaning depending on the culture. Some cultures consider finger or foot pointing respectful while others could consider a vigorous handshaking either a sign of aggression or a gesture of good will. Observe the family's interactions with others to determine what body gestures are acceptable and appropriate in their culture. When in doubt, ask.

Information from: Strategies for Working with Culturally Diverse Communities and Clients, Elizabeth Randall-David, PhD, June 1989

INFORMATION SHARING

Forms for agencies and individuals receiving service

Overview of Forms Used for Statistical Purposes

Overview of Forms Used in Individual Family Files

STATISTICAL INFORMATION AND REPORTS FOR INFANT DEVELOPMENT PROGRAMS

OVERVIEW

1. RECORD OF FAMILY CONTACT FORM

This form should be filled in weekly using the accompanying code sheet for interpretation. Statistics from this should be tabulated monthly to facilitate compiling annual statistics at year end. These monthly statistics should be filed with the annual statistics sheets.

2. MONTH END CASELOAD STATISTICS

This form should be filled in at month end and mailed to:

Provincial Advisor
Infant Development Program
2765 Osoyoos Crescent
Vancouver, B.C. V6T 1X7

3. CENTRAL REGISTRY FORM

Each Infant Development Program has a code letter assigned and individual children should be numbered in order of referral to the program. Supervisors must keep a separate file with infants names to correspond to code letter and number. The code letter and number on left side of this Registry represents infants who are accepted into active or follow-up caseloads, and receiving regular service from the program. It is recommended that new referrals be registered on this Registry as soon as they are accepted on the caseload. Review of this form should take place bi-annually to ensure up-to-date information is added to the form.

If the infant is referred for consultation or treatment by a therapist please note this under comments.

This Registry allows the Provincial Advisor to collate statistics provincially on numbers, ages, diagnosis, physio involvement, referral source, etc. of infants receiving service from Infant Development Programs.

4. ANNUAL STATISTICS FORM

Using information, in part, from the Record of Family Contact Form, supervisors should keep this form up-to-date. These statistics should be available to Sponsoring Societies and Local Advisory Committees, and the form or information included on it should be incorporated into the Annual Report.

RECORD OF FAMILY CONTACT

Month _____ Year _____

Characteristics of Contacts:		Number
Home Visit	H	_____
Therapist / Professional	*	_____
Hospital / Clinic	HOS	_____
Reports	R	_____
Telephone Visits	T	_____
Group	G	_____
Children Accepted	CA	_____
Children Discharged	CD	_____

Characteristics of Families	
Teen Parent	TP
Single (over 19) Parent	SP
Parent with a Disability	PD
Foster Parent	FP
Adoptive Parent	AP
First Nations	FN
English as a Second Language	ESL
Financial Resources	FR
Grandparent	GP

Active or Follow-Up	Child	Family Code	Week 1	Week 2	Week 3	Week 4	Week 5	Total HV

RECORD OF FAMILY CONTACT – CODE SOURCE

CHARACTERISTICS OF CONTACTS			
HOME VISIT	H	TELEPHONE VISITS	T
THERAPIST/PROFESSIONAL	*	GROUP	G
HOSPITAL/CLINIC	HOS	CHILD ACCEPTED	CA
REPORTS	R	CHILD DISCHARGED	CD

1. HOME VISIT: Record all home visits or other significant contacts made.....H
2. THERAPIST/PROFESSIONAL: Home visit with therapist/other professional.....H*
3. HOSPITAL/CLINIC: Visits made to hospital/clinic ..... HOS

   Visits made with therapists/professionals..... HOS*
4. REPORT: Report written and distributed to family/therapists/professionals.....R
   (record as one regardless of copies)
5. TELEPHONE VISITS: Calls made to family.....T
   (record only calls that take the place of home visit - not short calls to set appointments)

   Calls made to therapist/professional re child.....T*
   (only record calls that are like a home visit or clinic visit)
6. GROUP: Observation of child at group by IDP Consultant .....G
   Observation of child at group by therapist.....G*
7. CHILD ACCEPTED: When infant accepted on to the active or follow-up program caseload .CA
8. CHILD DISCHARGED: When infant referred elsewhere and no longer in program.....CD

CHARACTERISTICS OF FAMILIES			
TEEN PARENT	TP	ADOPTIVE PARENT	AP
SINGLE (OVER 19) PARENT	SP	FIRST NATIONS	FN
PARENT WITH A DISABILITY	PD	ENGLISH AS SECOND LANGUAGE	ESL
FOSTER PARENT	FP	FINANCIAL RESOURCES	FR
GRANDPARENT	*GP*		

It is understood that families may fit into one or more categories.

Parents have reported to us that being in any one or more of the family code categories presents parenting challenges. These extra challenges may result in the need for increased resources from Infant Development Programs and other services. For example, adoptive parents may not have easily accessible birth or medical information on their son or daughter. First Nations families may not be eligible for provincial services.

Financial Resources (FR) are documented only when the needs of the child exceed the ability of the family to manage financially (e.g., transportation costs, hearing aids, aids to mobility, respite, or poverty, etc.).

Must be on Agency letterhead

MONTH-END CASELOAD STATISTICS

Program: _____ Month: _____ Year: _____

Supervisor: _____

1. Active Caseload _____
2. Follow-up Caseload _____
3. Number of infants assessed _____
4. Number of infants currently monitored by the Program _____
5. Number of infants referred to Infant Dev. Program _____
6. Number of infants Accepted into Infant Dev. Program _____
7. Number of infants who left Infant Dev. Program _____
8. Number of foster families _____
9. Number of infants on Waiting List _____

1. Active Caseload: Home visits are made at least once/month.
2. Follow-up Caseload: Home visits or other contact less frequent than monthly
3. Number of Infants Assessed: Infants who have not been accepted onto caseload but have been assessed.
4. Number of Infants Currently Monitored by the Program: Examples of monitoring include the ASQ or monitored by staff and family through play group. Child not on active or follow-up caseload.
5. Number of Infants Referred to Infant Development Program: Total number of infants referred.
6. Number of Infants Accepted into Infant Development Program: Total number of new families receiving service on active or follow-up caseload.
7. Number of Infants Who Left Infant Development Program: Total number of infants who will no longer receive service from the Infant Development Program i.e. family moves, infant into pre-school (transition completed).
8. Number of Foster Families: In active caseload and follow-up caseload.
9. Number of Infants on Waiting List: Number of infants eligible for IDP but who are not accepted at this time because program caseload numbers are too high.

Infant Development Program

CENTRAL REGISTRY FORM

Name of Program

Code	Sex	D.O.B.	Residence	Date of Referral	Age at **REFERRAL** (Months)	Date Accepted	Referral Source	Reason for Referral	Characteristics of Family	Reason for Leaving	Date of Leaving

CENTRAL REGISTRY CODES

Referral Sources Codes

HOS	Hospital
MCF	Ministry for Children and Family Development
PAR	Parent
PHY	Physician
PHN	Public Health Nurse
PT	Physiotherapist
OT	Occupational Therapist
ST	Speech & Language Pathologist
IDP	Other IDP
O	Other

Characteristics of Family Codes

ESL	E.S.L. Family
FN	First Nations Family
FNS	First Nations Single Parent
FNT	First Nations Parent Under Age 19
FOS	Foster Family
MPT	Married Parent Under Age 19
PMD	Parent(s) with a Mental Disability
SP	Single Parent Family
SPT	Single Parent Under Age 19

Reason for Leaving Codes

C3	Child Reached Age 3
CCU	Child `Caught Up' to Norm
CR	Child Referred to Other Service
CD	Child Died
FM	Family Moved
FD	Family Chose to Discontinue
O	Other

Reason for Referral Codes

AID	AIDS
AR	At Risk
ARE	At Risk - Environmental
BP	Behaviour Problems
CP	Cerebral Palsy
DD1	Developmental Delay - 1 Area
DD2	Developmental Delay - 1+ Areas
DS	Down Syndrome
FTT	Failure to Thrive
FASD	Fetal Alcohol Spectrum Disorder
GA	Genetic Abnormality
HI	Hearing Impairment
HIV	HIV-Positive
HYD	Hydrocephalus
IGR	IGR/SGA
MEN	Mental Disability
MIC	Microcephaly
MUL	Multiple Disabilities
NAS	Neonatal Abstinence Syndrome
PHD	Physical Disability
PO	Prematurity - 32 weeks +
PU	Prematurity - 32 weeks -
PMO	Prematurity with Medical Complications - 32 weeks +
PMU	Prematurity with Medical Complications - 32 weeks -
SB	Spina Bifida
SD	Seizure Disorder
SF	Suspected FASD
VI	Vision Impairment
O	Other

ANNUAL STATISTICS FORM

Year _____ to Year _____

PROGRAM SUPERVISOR

SERVICES	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	TOTAL
CASELOAD													
CHILDREN ACCEPTED													
CHILDREN DISCHARGED													
CHILDREN ON WAIT LIST													
HOME VISITS													
HOME VISITS WITH THERAPISTS													
TOTAL HOME VISITS													
OBSERVATION OF CHILD AT GROUP													
REPORTS													
TELEPHONE VISITS													
PARENT/CHILD GROUP													
PARENT SUPPORT/EDUCATION GROUP													
IDP INSERVICE - # DAYS													
OTHER PROF. DEVELOPMENT													
COMMUNITY EDUCATION													
MEETINGS													

NOTE: Refer to Record of Family Contact (page 122) and Other Program Services (page 128)

OTHER PROGRAM SERVICES

To be filled out by IDP Supervisor in consultation with IDP Consultants. This information, if gathered monthly, will facilitate year end reporting.

For Parents in IDP – Monthly

Assessments/Monitoring for children not on program		# of families _____
Case Review Committee		# of hours _____
Parent/child group	# of sessions_____	# of hours _____
Parent support groups	# of sessions _____	# of hours _____
Parent education program	# of sessions _____	# of hours _____
Mailings to parents		# of mailings _____

Staff Training/Student Placement

Practicum for IDP Consultant	# of days _____
Practicum for students (e.g., E.C.E.)	# of days _____
Observation of other programs	# of hours _____
IDP Inservice	total days for all staff _____
Other professional development:	
Workshops / conferences	total days for all staff _____
UBC Summer Institute	total days for all staff _____
Other university courses related to field	total days for all staff _____
Total days other professional development	_____

Community Education

Public speaking on the Program	# of hours _____
General parent education (Well Baby Clinics)	# of hours _____
Teaching parenting courses (Nobody's Perfect)	# of hours _____
Presentations to post secondary institutions	# of hours _____
Mailings to professional community	# of mailings _____

Administration

Staff meetings	# of hours _____
Local advisory committee meetings	# of hours _____
Board meetings	# of hours _____

FORMS FOR INDIVIDUAL FILES

MODEL OF FILE MAINTENANCE

The number in brackets following the form name refers to its description in the Overview on the following pages.

Section 1

Child and Family Information

- Referral (1)
- Medical Form (2)
- Consent Form (3)
- Consent / Request for Specific Information (3)
- Letter to Referral Source (4)

Section 2

Program Information

- Parent Checklist (6)
- Other Family Surveys (7)
- Home Visit Record (8)
- Family Contact Sheet (9)

Section 3

Assessments

- Goals and Objectives (10)
- Individual Family Service Plan (11)

Section 4

Professional Reports and Correspondence

- Letter Requesting Medical Referral to the Consultant Physiotherapist (5)
- Therapy reports
- Correspondence with physicians, paediatricians, specialists

Section 5

Other

- Diagnosis/ information (research etc.)
- Toys and books lent

Section 6

Closure

- Closing Information Form (12)
- Transition Plan
- Closing Letter sent to Referral Source (13)

OVERVIEW

1. REFERRAL FORM

Use the Referral form (page 133) as soon as the applicant requests Infant Development Program service. Complete with information from the referral source and/or family by telephone/letter and/or during the initial home visit by Infant Development Program staff. If the family is accepted into the caseload or placed on a weighted waiting list, staple the referral form to the inside of the infant's file. If the family is not eligible for Infant Development Program service keep the referral form in a separate file entitled "Ineligible for Service" to bring to the attention of the Case Review Committee. It is useful to review this file from time to time to identify patterns of inappropriate referrals and to develop ways to educate referral sources as to what constitutes eligibility for Infant Development Program service.

2. MEDICAL FORM (PAGE 134)

This form should be part of a child's file on which to record relevant information. Please note the hearing and vision section and ensure regular screening takes place.

3. CONSENT FORMS

There are 2 types of consent forms.

1. Consent for Service: Families must give informed consent for service and either sign the bottom of the referral form or sign a separate form. Families must also sign that they received their parent information package. Again this can be done at the bottom of the referral form or on a separate form. Copies of forms must be left with family and consent must be reviewed annually.
2. Consent / Request for Specific Information (page 136) This is consent requested or specific information to be shared with another professional. Indicate specifically information to be shared. This consent form is also left with the family and expires 90 days after date of signing.

Issues of confidentiality should be discussed with the family at this time. These issues will include the following:

- Reports by Infant Development Program staff on individual infants are sent to the family with copies to involved professionals with parental consent.
- Some sharing of information with other professionals is necessary to ensure the program for the infant and family is as comprehensive as possible. Some agencies have a central file open to all professionals in that agency.
- The role of the case review committee as it relates to the above should be discussed
- The file kept by the Infant Development Program staff is open to the family.

4. LETTER TO REFERRAL SOURCE (PAGE 137)

Letter must be sent to referral source indicating that contact has been made with the family.

5. LETTER REQUESTING MEDICAL REFERRAL TO THE CONSULTANT PHYSIOTHERAPIST (PAGE 138)

This request should be drafted using the form letter as a model, in consultation with the Case Review Committee and the consulting physiotherapist, as some agencies and/or physiotherapists require a medical referral for physiotherapy assessment, and others do not.

6. PARENT CHECKLISTS

The Parent Checklist (page 139) should be filled in by staff and family within one month of referral to the program and, at a minimum, bi-annually thereafter. The information gathered may help to clarify goals and objectives for parents and staff.

7. OTHER FAMILY SURVEYS

Some families may benefit from using more detailed parent surveys My Child and Family (page 140) and Family Needs Survey (page 143). Staff should also be familiar with these tools to remind them of the range of issues facing families in their child raising role. Some tools are highly specific, such as the Family Checklist on Down Syndrome (page 195). It is not appropriate to use these tools if families regard them as intrusive.

8. HOME VISIT RECORD (PAGE 159)

Each home visit must be recorded in duplicate preferably during the course of the home visit, with one copy in the Infant Development Program infant file and one copy to the parent. This form is a guide to information that should be recorded in a systematic way.

9. FAMILY CONTACT SHEET (PAGE 160)

10. GOALS AND OBJECTIVES SHEET (PAGE 161)

Goals and objectives will be developed with the family and other consulting professionals after the administration of the Parent Checklist, the Gesell and/or other child/family assessment tools. This should be done within two months of referral to the Infant Development Program. Decisions relating to establishing goals and objectives should be based on the following:

- family's priorities and concerns
- developmental status of infant
- time, interest and teaching style of family
- learning style and interests of infant
- availability of other support/intervention services

A variety of methods of recording goals and objectives are included. These range from a traditional, child-focused goal and objective sheet, sheets on which to record activity-based goals and objectives, and a form designed to assist parents to identify and prioritize goals and objectives. Staff and family interests and abilities should determine which method of recording is best, recognizing that this may change over time for some families and infants. Goals should be reassessed monthly or more frequently and new objectives developed as needed. It is expected that the IDP library will contain a number of curricula that provide more detail in program design (e.g., Carolina, A.E.P.S., and Hanen).

11. INDIVIDUAL FAMILY SERVICE PLAN (PAGE 162)

An Individual Family Service Plan (IFSP) is a framework designed to enable families and professionals to work together as a team. The purpose of their combined and organized effort is to identify strengths and needs of the family and available resources, and to match these in accordance with family chosen goals. The IFSP is mandated by law in the U.S.A. for all families receiving publicly funded services for young children with special needs. Many American publications describe the IFSP in detail.

There are no such legal requirements in Canada and, indeed, many American critics of the IFSP define it as cumbersome, time consuming and non productive. However, there are situations where such a plan may well be in the interests of some families. In addition, an IFSP for every family is a requirement for accreditation. The purpose is to ensure documentation of goals and a documented note that these goals are revisited and updated to ensure ongoing work with the family.

An IFSP may be **simple** or complex depending on child and family need and circumstance.

An IFSP must include the following:

- Child's name
- Date of birth
- Concerns / strengths
- Goals / action plan
- Signature of parent and IDP consultant

Gesell or **assessment** reports done in the Infant Development Program every six months serve a similar function to an IFSP and may be expanded when necessary to become an IFSP.

For accreditation purposes, you can use the Gesell report for an IFSP but that needs to be stated. Add additional **documentation** if necessary to outline the goals. If the parents' goals are different from the report add additional information.

12. CLOSING INFORMATION FORM (PAGE 169)

This form is to be completed with appropriate signatures. A copy of this form will be given to the parent(s) when the file is closed and they will be given a copy of the transition plan.

13. CLOSING LETTER SENT TO REFERRAL SOURCE (PAGE 170)

It is a **requirement** of accreditation that the referral source be notified in writing when a file is closed.

Must be on agency letterhead

REFERRAL FORM

FAMILY INFORMATION

Name of Infant: _____

D.O.B._____

Age at Referral: _____Gender: _____

Mother's Name: _____

Father's Name: _____

Address: _____

_____

Telephone (H)_____ (W)_____

Siblings

Name: _____Age: ____

Name: _____Age: ____

Name: _____Age: ____

REFERRAL DATA

Date of Referral _____

Referral Source: _____

Reason for Referral _____

BIRTH INFORMATION

Hospital: _____

Birth Weight: _____

Gestational Age: _____

Agencies Involved

Foster Child: Yes_____ No_____

Name of Agency Name of Worker

_____

_____

Diagnosis / Additional Information

_____

_____

Assessments	**Type**	**By Whom**	**Date**

_____

_____

Physicians **Medical Concerns**

_____

_____

Does the family require an interpreter? Yes: ___ No: ___ Language: _____

Are there any cultural or religious observances of which we should be aware?

_____

Do you have any information that may indicate a potential risk to a home visitor?

_____

Additional Comments: _____

_____

Parent is informed about the IDP and wishes to participate.

Parent has been given the Parent Information Package. This consent is reviewed annually.

IDP Consultant Signature_____

Parent Signature _____

Must be on agency letterhead

MEDICAL FORM

NAME: _____ DATE: _____

PRENATAL INFORMATION:

_____

_____

_____

BIRTH INFORMATION:

_____

_____

_____

MEDICAL INTERVENTION AFTER BIRTH AND / OR SUBSEQUENT HOSPITALIZATION

Date	Reason (treatment, hospitalization, tests, etc.)
_____	_____
_____	_____
_____	_____

HEARING CHECKUP Date	VISION CHECKUP Date	DEVELOPMENTAL CHECKUP Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Information

_____

_____

_____

Must be on agency letterhead

CONSENT FORM

I give my permission to the staff of the _____

Infant Development Program to receive from and/or send to the following persons or agencies, relevant information, reports, etc. about my child:

_____

Name of Professional/Agency	Date	Parent Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Case Review Committee

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Expiry date: _____ (Review annually)

Leave copy with family.

Must be on agency letterhead

CONSENT / REQUEST FOR SPECIFIC INFORMATION

Address: _____

Date: _____

Dear _____

Child's Name: _____

D.O.B. _____

was referred to the Infant Development Program on _____

by _____

I have made an initial home visit with this family. The parent(s) and I feel the Infant Development Program may be of benefit to the child and family. I have included the parental consent to share information and regular developmental reports with you and to obtain from you, information that will be of assistance to us in planning a program for the child and family. I would be pleased to cooperate with you in the planning and provision of service to this family.

Please send me the following information: _____

_____

_____

OR

I have made an initial home visit with this family. The parent(s) and I feel the Infant Development Program may be of benefit to the child and family. However, the family does not wish to share information at this time.

Yours sincerely,

_____

Infant Development Program Consultant

_____

Parent Signature

_____

Date

This consent expires 90 days following date of signing.

Must be on agency letterhead

LETTER TO REFERRAL SOURCE

Address: _____

Date: _____

Dear _____

Child's Name: _____

D.O.B. _____

Thank you for your referral to the Infant Development Program. An initial home visit has been made and the family wishes to participate in the Program.

OR

Thank you for your referral to the Infant Development Program. An initial home visit has been made, however the family does not wish to participate in the Program.

Yours sincerely,

_____ , Consultant

REQUEST FOR MEDICAL REFERRAL TO THE CONSULTANT PHYSIOTHERAPIST

Re: _____

Date of Birth: _____

Parents: _____

Address: _____

Dear _____

_____ was referred to the Infant Development Program on _____

by _____

The reason for referral was _____ .

_____

_____

This child has been accepted into the Infant Development Program, and I will be making regular home visits. Copies of my reports to the family will be sent to you at their request.

In addition to regular home visits by me, the Infant Development Program provides an initial screening / assessment by a Registered Paediatric Physiotherapist. In compliance with the Physiotherapist Act, that service is available only with a physician's referral. Enclosed is a referral form which we ask you to sign and return to the office indicated on the form.

I would be pleased to cooperate with you in the planning and provision for services to this family. If you have any questions regarding the Infant Development Program, or require any additional information, please contact me.

Sincerely,

_____

Infant Development Consultant

PARENT CHECKLIST FOR HOME VISIT

Child's name: _____

Date: _____

		YES	NO
1.	We would like to know more about child development	_____	_____
	a. feeding	_____	_____
	b. sleep patterns	_____	_____
	c. toilet learning	_____	_____
	d. motor activities	_____	_____
	e. language	_____	_____
	f. social skills	_____	_____
	g. play	_____	_____
	h. temperament	_____	_____
	i. other (specify)	_____	_____
2.	We would like to meet other parents who have a child with similar needs....	_____	_____
3.	We need more information on other services or community resources	_____	_____
4.	We would like to know more about parenting skills	_____	_____
5.	We would like to know more about our child's delay, problem or disability	_____	_____

6. Our immediate needs are:

_____

_____

MY CHILD AND FAMILY

Name: _____

How would you describe your child's temperament? (i.e., easy going, slow to warm up)

_____

_____

Your Child's Strengths:

Physical:

_____

_____

Interactions:

a) What objects does your child like to play with and how does he / she use them?

_____

_____

b) How does he / she interact with people?

_____

_____

Communication:

a) Verbal

_____

b) Non-Verbal

_____

c) Understanding

_____

_____

Likes:

What do you and your child like to do together? _____

_____

Family Routines

Meal times: _____

Types of food your child eats: _____

Problems: _____

Pleasures: _____

Sleep:

Naps: _____

Bedtime: _____

Problems: _____

Pleasures: _____

Bath Time:

Problems: _____

Pleasures: _____

Community:

Where does your child go outside the home? (i.e., shopping, car, friends, etc.)

_____

_____

Behaviour / Pleasures / Problems:

How do you know when your child wants attention: comfort, to be played with, food/drink, or a toy?

_____

_____

How do you know when your child is over-stimulated or bored, having fun or tired?

_____

_____

Activities I like doing with my child are: _____

_____

Activities I dislike doing with my child are: _____

_____

Briefly describe your understanding of your child's delay: _____

_____

Complete the following sentences with the first thought that comes to mind:

It will make a big difference when my child can _____

_____

_____

I really feel I could use some help with _____

_____

_____

Family Support:

Do you have the support of extended family or close friends in the area?

_____

_____

Do you ever go out without your child? _____

If yes, do you have a reliable babysitter? _____

If no, would you like information about a respite program? _____

Additional Information: _____

_____

_____

Follow Up Plans:

_____

_____

Date: _____ Child's Name: _____

Filled in by: _____

IDP Consultant: _____

FAMILY NEEDS SURVEY

The following checklist includes needs that are commonly expressed by parents of young children with special needs. Mothers and fathers often have different needs so we recommend that both parents each fill in the checklist if possible. Please read each statement. If it is definitely not a need for you circle #1. If you are not sure whether you want help in this area circle #2. If it is definitely a need for you at this time circle #3. Some of the needs you have may be met through your Infant Development Program or through other community resources recommended by the Infant Development Program. Some needs may be met by your family, friends or other community contacts, such as parent groups. This list can help you and your Infant Development Consultant to plan and to set priorities to meet your needs.

1: I Don't Need Help 2: Not Sure 3: I Need Help

A. NEED FOR INFORMATION

1.	I need more information about my child's condition or disability	1	2	3
2.	I need more information about my child's behaviour	1	2	3
3.	I need more information about how to teach my child	1	2	3
4.	I need more information on how to play with or talk to my child	1	2	3
5.	I need more information on services that are presently available for my child	1	2	3
6.	I need more information about services that my child might receive in the future	1	2	3
7.	I need more information about how children grow and develop	1	2	3

B. NEED FOR SUPPORT

1.	I need to have someone in my family that I can talk to more about problems.	1	2	3
2.	I need to have more friends that I can talk to.	1	2	3
3.	I need to have more opportunities to meet and talk with other parents of children with special needs.	1	2	3
4.	I need to have more time just to talk with my child's teacher or therapist.	1	2	3
5.	I would like to meet more regularly with a counsellor (psychologist, social worker, psychiatrist) to talk about problems.	1	2	3
6.	I need to talk more to a minister who could help me deal with problems.	1	2	3
7.	I need reading material about other parents who have a child similar to mine.	1	2	3
8.	I need to have more time for myself.	1	2	3

C. EXPLAINING TO OTHERS

1.	I need more help in how to explain my child's condition to his/her siblings.	1	2	3
2.	I need more help in explaining my child's condition to my parents or my spouse's parents.	1	2	3
3.	My spouse needs help in understanding and accepting our child's condition.	1	2	3
4.	I need help in knowing how to respond when friends, neighbours, or strangers ask questions about my child's condition.	1	2	3
5.	I need help in explaining my child's condition to other children.	1	2	3

D. COMMUNITY SERVICES

1.	I need help locating a doctor who understands me and my child's needs.	1	2	3
2.	I need help locating a dentist who will see my child.	1	2	3
3.	I need help locating babysitters or respite care providers who are willing and able to care for my child.	1	2	3
4.	I need help locating a day care centre or preschool for my child.	1	2	3
5.	I need help in getting appropriate care for my child in our church or synagogue nursery during church services.	1	2	3

E. FINANCIAL NEEDS

1.	I need more help in paying for expenses such as food, housing, medical care, clothing or transportation.	1	2	3
2.	I need more help in getting special equipment for my child's needs.	1	2	3
3.	I need more help in paying for therapy, day care, or other services for my child.	1	2	3
4.	I or my spouse need more counselling or help in getting a job.	1	2	3
5.	I need more help paying for babysitting or respite care.	1	2	3
6.	I need help paying for toys that my child needs.	1	2	3

F. FAMILY FUNCTIONING

1.	Our family needs help in discussing problems and reaching solutions.	1	2	3
2.	Our family needs help in learning how to support each other during difficult times.	1	2	3
3.	Our family needs help in deciding who will do household chores, child care, and other family tasks.	1	2	3
4.	Our family needs help in deciding on and doing recreational activities.	1	2	3

G. COMMENTS

_____

_____

_____

_____

_____

_____

Adapted with permission from material prepared by Rune Simeonsson, Ph.D. and Don Bailey, Ph.D., Chapel Hill, North Carolina.

PAN Parent Assessment of Needs

PAVII PROJECT
PARENTS AND VISUALLY IMPAIRED INFANTS
50 Oak St., Room 102, San Francisco, CA 94102

PURPOSE

The PAN is an informal and flexible assessment to be used with parents of infants and toddlers who are visually impaired. It encourages parents to identify educational objectives for their child by:

a) Identifying baseline behaviors

b) Prioritizing parent-child activities

The PAN creates a PROCESS which helps parents to:

a) Recognize developmentally appropriate skills

b) Understand needs from their child's perspective

c) Develop parent-child activities which fit into the family routine

d) Identify and develop their role in educational assessment

The PAN was conceived from existing ecological inventories for older children such as the ICSM (Individualized Critical Skills Model of the Special Education Resource Network, Sacramento, CA). The range of items and types of questions must be ecologically-valid and chronologically-age appropriate. Thus the PAN may be modified or extended to "fit" the needs of other young children.

DIRECTIONS FOR USE

The PAN may be completed in the following ways:

1. Parent interview
2. Written parent report
3. Combination of parent interview and written report

The method for completing the PAN should be determined by parent preference and by the program staff's knowledge of the family. The interview method should be used with parents who may have difficulty completing the form.

Completed PANs should be reviewed by program staff with the parent in order to:

1. Identify intervention goals for the child
2. Develop activities to meet these goals
3. Discuss developmentally appropriate and functional skill sequences with the parent.

The format of the PAN is simple and self-explanatory. The form is composed of the following:

1. A checklist for the following skill areas: orientation and mobility, interaction with objects and interaction with people. Skill sequences are not age-normed.

Parents are asked to describe baseline or current behaviour including emerging skills, and then to identify an immediate goal.

2. A series of questions which ask what the child does in home routines, family and community activities.

3. A series of questions concerning child communication, child preferences, parent preferences, parental understanding of the child's disabilities, and parent identification of priorities for their child.

The PAN format provides for "First Report" and "Follow-up" use.
Repeated administrations serve to:

a) Document child progress
b) Identify child characteristics
c) Identify changes in parent priorities

The PAN is a gentle introduction to educational assessment. The parent takes a major role in the assessment process, determines child goals and becomes a vital member of the intervention team. It is expected that this experience will facilitate active decision-making by parents in future IDP development and child advocacy roles.

PAVII PROJECT

PARENTS AND VISUALLY IMPAIRED INFANTS
5O OAK STREET, ROOM 102, SAN FRANCISCO, CA 94102. (415) 863-2250

Deborah Chen. Ph.D., Project Director • Clare Taylor Friedman, Ph.D., Project Coordinator

Gail Calvello, MA., Parent-Infant Educator

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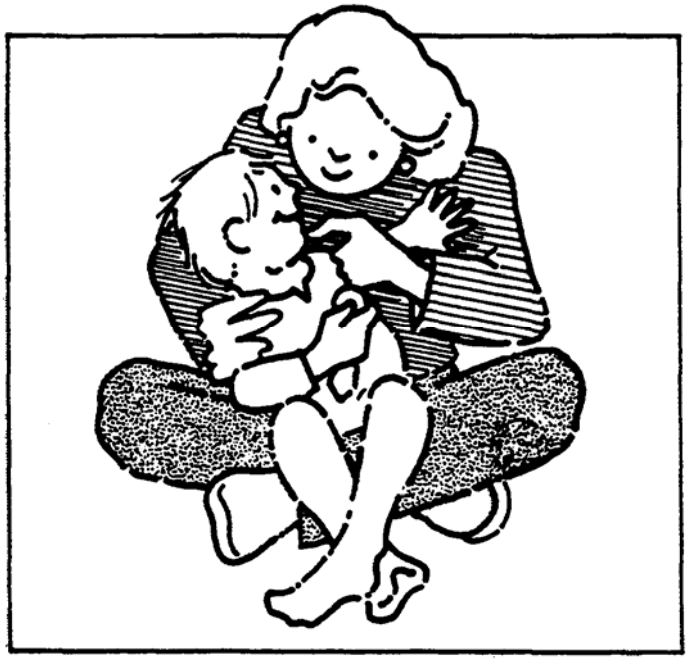
PAN



Child's Name: _____ Age: _____ Date of Birth: _____

Parents / Guardian
Completing this form: _____

Date of first Report: _____ Date of Follow-Up: _____

PAVII PROJECT

PARENTS AND VISUALLY IMPAIRED INFANTS

5O OAK STREET, ROOM 102, SAN FRANCISCO, CA 94102. (415) 863-2250

Deborah Chen, Ph.D., Project Director • Clare Taylor Friedman, Ph.D., Project Coordinator

Gail Calvello, MA., Parent-Infant Educator

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ORIENTATION AND MOBILITY

Check what your child does now:

- 1 Lifts head while on tummy or held at shoulder
- 1 Elevates self by arms when prone (on tummy)
- 1 Rolls
- 1 Sits
- 1 Crawls on tummy
- 1 Creeps on knees
- 1 Pulls to stand
- 1 Cruises (takes steps to side holding on to furniture)
- 1 Walks with support
- 1 Walks alone
- 1 Uses riding toys, playground equipment

FIRST REPORT DATE _____	*FOLLOW-UP* DATE _____
Describe what your child does now, including emerging skills:	Describe what your child does now, including emerging skills:
What would you like your child to do next?	What would you like your child to do next?

INTERACTION WITH OBJECTS

Check what your child does now:

- 1 Grasps rattle placed in hand
- 1 Shakes and mouths objects
- 1 Swipes at objects
- 1 Grasps objects placed on chest, looks at it (if applicable)
- 1 Bangs objects against surface
- 1 Transfers objects between hands
- 1 Brings hands together to bang objects or to clap
- 1 Takes objects out of container
- 1 Puts objects in container
- 1 Plays with manipulative toys, e.g. busy box, musical toys, form board
- 1 Enjoys messy play, e.g. paint, water, sand, playdough

FIRST REPORT DATE _____	*FOLLOW-UP* DATE _____
Favourite objects?	Favourite objects?
Reactions to unfamiliar objects?	Reactions to unfamiliar objects?
Describe what your child does now, including emerging skills:	Describe what your child does now, including emerging skills:
What would you like your child to do next?	What would you like your child to do next?

INTERACTION WITH PEOPLE

Check what your child does now:

- 1 Quiets when spoken to or held
- 1 Smiles to parent's face, and/or when tickled or jostled
- 1 Explores parent's face or body
- 1 Watches or listens to nearby activity
- 1 Demands individual attention
- 1 Reaches for attention
- 1 Participates in social games, e.g. vocal play, "peek-a-boo", rough and tumble games

FIRST REPORT DATE _____	*FOLLOW-UP* DATE _____
Describe what your child does now, including emerging skills:	Describe what your child does now, including emerging skills:
What would you like your child to do next?	What would you like your child to do next?
Favourite people?	Favourite people?
Reactions to unfamiliar people?	Reactions to unfamiliar people?

HOME ROUTINES

MEAL TIME *FIRST REPORT* DATE ___	*FOLLOW-UP* DATE ____
1. Where does your child have meals?	
2. Who does your child eat with?	
3. What does your child eat?	
4. Does your child finger feed? Use spoon, fork, or cup?	
5. Food likes:	
Food dislikes:	
6. Pleasures:	
Problems:	
Goals?	
DRESSING	
1. Where does your child dress and undress?	
2. What does your child do?	
3. Who helps your child?	
4. Pleasures:	
Problems:	

FIRST REPORT DATE	*FOLLOW-UP* DATE
Goals?	
BATH TIME	
1. Where does your child have a bath?	
2. What does your child do?	
3. Who bathes your child?	
4. Pleasures	
Problems	
Goals?	
TOILETING (If applicable)	
1. Does your child seem to have a schedule or predictable dry periods?	
2. Is your child aware of wet or soiled pants?	
3. Is your child put on the potty? If so, when and for how long?	
4. How does your child participate in the potty routine?	
Goals?	
BED TIME	
1. What is your child's sleep schedule?	
FIRST REPORT DATE	*FOLLOW-UP* DATE

2. Where does your child fall asleep?	
3. Does your child have a bed-time routine? For example, favourite activities, toys or people?	
4. Pleasures:	
Problems:	
Goals?	

FAMILY ACTIVITIES

1. What does your child enjoy doing with family members?	
2. How is your child involved in family leisure time?	
3. Pleasures:	
Problems:	
Goals?	

COMMUNITY ACTIVITIES

FIRST REPORT DATE	*FOLLOW-UP* DATE
1. what does your child do outside the home?	
- at other people's homes?	
- at the doctor's office?	
- at the store?	
- at the park?	
- other places?	
2. Pleasures	
Problems:	
Goals?	

COMMUNICATION

1. How do you know when your child wants attention, comfort, to be played with, food/drink, a toy?	
2. How do you know when your child is over-stimulated or bored, having fun, or is tired?	
3. Pleasures:	
FIRST REPORT DATE	*FOLLOW-UP* DATE

Problems:	
Goals?	

HOW ABOUT YOU?

1. Activities I like doing with my child:

FIRST REPORT _____

FOLLOW-UP _____

2. Activities I dislike doing with my child:

FIRST REPORT _____

FOLLOW-UP _____

3. Briefly describe your understanding of your child's visual impairment and/or other impairments:

FIRST REPORT _____

FOLLOW-UP _____

4. How do you feel your child's visual impairment and/or other impairments have affected his/her development?

FIRST REPORT _____

FOLLOW-UP _____

5. Complete this sentence with the first thought that comes to mind:
   "It will make a big difference when my child can…"

FIRST REPORT _____

FOLLOW-UP _____

6. "During this year, I would like my child to learn how to…"

FIRST REPORT _____

FOLLOW-UP _____

PRIORITIES

Please list what you want to work on with your child, in order of importance:

Most important

FIRST REPORT _____

FOLLOW-UP _____

Second-most important

FIRST REPORT _____

FOLLOW-UP _____

Third-most important

FIRST REPORT _____

FOLLOW-UP _____

OTHER QUESTIONS OR CONCERNS

_____

_____

_____

_____

_____

_____

_____

Must be on Agency letterhead

HOME VISIT RECORD

Name: _____ Date: _____

Progress on Current Program: _____

_____

_____

_____

_____

_____

_____

_____

New Activities: _____

_____

_____

_____

_____

_____

Materials Left: _____

_____

General Remarks: _____

_____

_____

_____

Follow-up: _____

Consultant Signature: _____

FAMILY CONTACT SHEET

Child's Name:						
File Number:						
Date	**Ph**	**HV**	**Phy**	**Oth**	**Corresp**	**Notes**

Ph: Phone **HV**: Home Visit **Phy**: Physio **Oth**: Other

GOALS AND OBJECTIVES

PROGRAM_____ CHILD'S NAME_____AGE (Months) WHEN GOALS SET

IDP CONSULTANT_____ D.O.B._____AGE (Months) WHEN GOALS ASSESSED

DATE GOALS SET_____ DATE GOALS ASSESSED_____

CODE:

+ + **Behaviour part of sequence**
+ **Behaviour well established**
+ — **Behaviour inconsistent**
— **Behaviour not present**

SKILL AREA	GOALS	PROGRESS	COMMENTS
MOTOR			
ADAPTIVE			
LANGUAGE			
PERSONAL/SOCIAL			

Parent Signature _____

INDIVIDUAL FAMILY SERVICE PLAN

Child's Name: _____ Age: _____

Diagnosis (if any): _____ Date referred: _____

Date of most recent visit: _____ Consultant: _____

Date presented: _____

Medical / Health / Development Past / Current			
Parents' Concerns			
Agencies Involved	***1.***	***2.***	***3.***
	4.	***5.***	***6.***
	7.	***8.***	***9.***
Assessments Completed	***1.***	***2.***	***3.***
	4.	***5.***	***6.***
	7.	***8.***	***9.***
Assessments to be Completed	***1.***	***2.***	***3.***
	4.	***5.***	***6.***
Referrals Completed	***1.***	***2.***	***3.***
	4.	***5.***	***6.***
	7.	***8.***	***9.***
Referrals Needed	***1.***	***2.***	***3.***
	4.	***5.***	***6.***
	7.	***8.***	***9.***

Equipment / Resources on Loan	***1.***	***2.***	***3.***
	4.	***5.***	***6.***
	7.	***8.***	***9.***
Equipment / Resources Needed	***1.***	***2.***	***3.***
	4.	***5.***	***6.***
	7.	***8.***	***9.***
Goals / Recommendations			
Transition Plans			

I agree with this plan.

Parent Signature: _____ Date: _____

If not Initial FSP, goals from previous FSP: met ❑ revisited ❑ progress made ❑

Questions to ask parent when filling in Family Service Plan

SAMPLE

PARENT GOAL PLANNING

Child's Name: _____ Date: _____

_____

_____

Over the next 6 months, what would you see as your main goals for your child's development?

_____

_____

_____

Large muscles (walking, running):

_____

_____

Small muscles (use of hands):

_____

_____

Learning about the world:

_____

_____

Language:

_____

_____

Social:

_____

_____

Play:

- Talking with others:
- Feeding:
- Dressing:
- Toilet training:
- Other:

Which of these would you consider to be your highest priority?

_____

_____

How can I (Infant Development Consultant) assist you in reaching these goals for your child?

_____

_____

Practical Suggestions - What materials or information might help your child reach his/her goals?

- Reading materials:
- Developmental toys:
- Practical suggestions for activities to do with your child:
- Information on your child's development:
- Other:

Do you have a goal(s) for yourself in working with your child or your family?

_____

_____

Would you share them with me (optional)?

_____

_____

Is there some way I can assist you in reaching this goal / goals?

- Reading materials: _____
- Contact with others:_____
- Parents: _____
- Other services (Child Care): _____
- Professionals: _____
- Other: _____

Based on work done by the Prince George Infant Development Program

ACTIVITY PLANNING

Child: _____

Objective: _____

Activity – Setting	People - Materials	Strategy	Child's Actions

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Dr. Kristine Slentz, Center on Human Development, 901 E. 18th Avenue, Eugene, OR 97403.

ACTIVITY PLANNING – SAMPLE

Child: _____

Objective: Child initiates communication with familiar adult.

_____

Activity - Setting	People - Materials	Strategy	Child's Actions
Mealtime	Favourite foods Difficult to open transparent container	Place favourite food inside container -- wait for child to request assistance to open container	Child verbalizes "open", "help", etc. Child hands container to adult and points to lid.
Playtime	Toys, objects, interactive games	Introduce unusual events, e.g., interrupt favourite game; stop "chasing" child; turn off light. Introduce novel objects, e.g., while child is placing blocks in box, give child toy animal.	Child verbalizes "more", "play", "off", "on", etc. Child expresses surprise, "oh", or labels animal.

STRUCTURED DATA COLLECTION FORM

Child: _____

Objective: _____

DATE TIME	**ACTIVITY - SETTING**	Strategy	Child's Response				Comments
			+	—	No Response	Other	

Printed with permission from:
Dr. Kristine Slentz, Center on Human Development, 901 E. 18th Avenue, Eugene, OR 97403
Dr. Carl Dunst, Summer Institute, University of B.C., 1993

CLOSING INFORMATION FORM

Date: _____

Name of Parents: _____ Name of Infant: _____

Address: _____ DOB: _____

_____ Age Referred to IDP: _____

Telephone: H _____W: _____ Age on Leaving _____

Diagnosis at referral: _____

Diagnosis on leaving: _____

Assessments Done Service to Family Initiated by IDP

Date Assessment Used Done By _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Future Consultation will be provided by: _____ Telephone: _____

Follow-Up Plans _____

_____

Preschool Choice by Parents: _____

Reason for Choice: _____

Staff Signature: _____

Post survey sent: _____

Need a closing file procedure listed for your agency _____

Need a closing office procedure for your office _____

Must be on Agency letterhead

CLOSING LETTER SENT TO REFERRAL SOURCE

Date

Address

Re: _____ (Child's Name) D.O.B. _____

Dear _____

This is to inform you that _____ file has been closed with the Infant Development Program.

(Briefly explain reasons for file closure)

Thank you for your continued involvement with the Infant Development Program.

Yours sincerely,

_____ Consultant
Infant Development Program

APPENDIX III-A WAITLIST SAMPLE LETTER

October 12, 2001

Ms. and Mr. B
12345 92 Avenue
Surrey, BC

Dear Ms. and Mr. B:

D H, Public Health Nurse, referred J to the Surrey / White Rock Infant Development Program. This is just to let you know that we are processing the referral and will be assigning a consultant as soon as possible.

While you are waiting for your consultant to be assigned, you are welcome to attend our weekly playgroups. The Surrey playgroup is from 9:30 to 11:00 Wednesday mornings at 301A - 8352 130 Street in Surrey. The White Rock playgroup is at Peace Arch Community Services, 882 Maple Street, on Tuesday mornings from 9:30 to 11:00. Consultants will be on hand to answer any questions you may have about your child's development at this point.

Enclosed, you will find a brochure describing the Infant Development Program for your information, as well as a Client's Rights form which we ask you to read over very carefully. Please feel free to call me if you have any questions or concerns.

Sincerely,

Jane Scott Program Manager

APPENDIX III-B ADMISSION FORM CHECKLIST

	ITEM	CHECK	NOTES
1.	Infant Development Program Book **(handout)**		
2.	Grievance Policy **(handout)**		
3.	Infant Massage Pamphlet **(handout)**		
4.	What is IDP? **(handout)**		
5.	Toy Library Information **(handout)**		
6.	Application for Service **(SIGN)**		
7.	Consent for Release of Information **(SIGN)**		
8.	Review IDP Referral Form **(SIGN)**		
9.	IDP Admission Form Checklist **(SIGN)**		
10.	Review Recording Procedures		
11.	Review Medical Form		

I, _____ , agree that the above information has been explained to me and that I have received the handouts.

Parent / Guardian Signature _____ Date _____

IDP Consultant Signature _____ Date _____

APPENDIX III-C INDIVIDUAL FAMILY SERVICE PLAN

Child's Name: _____ Date of Birth: _____

Parents / Caregiver: _____

Diagnosis (if any): _____

Date of Referral: _____ Date of IFSP Meeting: _____

Dates of Review: _____

_____

_____

_____

IFSP PLANNING TEAM

Name	Relation to Child	Agency

I / We agree that this plan represents my / our wishes.

_____ _____

Parent Signature IDP Consultant Signature

PRESENT LEVEL OF DEVELOPMENT

AREA	DATE	COMMENTS
Vision		
Hearing		
Gross Motor		
Fine Motor		
Adaptive Behaviour		
Personal / Social		
Speech / Language		
Other:		

Relevant Health Information:

FAMILY IDENTIFIED GOALS

Child's Name: _____

Date of Birth: _____

Date Goal Set: _____

Goal: _____

_____

_____

_____

Strategies: _____

_____

_____

_____

Resources Needed: _____

_____

_____

_____

Plan Review for this Goal: _____

_____

_____

Parent Evaluation Key: 1. No longer a need: 2. Still a need: 3. Need partially met: 4. Need met: 5. Goal revised:	Date of review: _____ Evaluation outcome: _____ Date of review: _____ Evaluation outcome: _____

I have participated in and agree with the above plan.

Parent Signature: _____

Consultant Signature: _____

Progress will be reviewed _____ (how often),

By _____

_____

APPENDIX III-D OPENING AND CLOSING DATA

Child's Name: _____

Date of Referral: _____

Date on Caseload: _____

No. of Months Waiting: _____

A Referral Letter Mailed: _____

Initial Contact - Date & Info: _____

_____

_____

Physio Referral Letter Mailed: _____ to Dr. _____
Referral Source Informed of Receipt of Referral and Outcome:

_____

Date Closed: _____ Survey Sent: _____

Reason Closed:

Age 3: _____ Moved: _____

IDP Not Needed: _____ Referred elsewhere: _____

Caught Up: _____ Child Died: _____

Family Declined Service: _____ Other: _____

Referral Source Informed of Closure: _____

Number of Months on the Program:

No Preschool Yet: _____ Yes Preschool: _____

Name: _____ Supported Child Care: _____

Closing Notes: _____

_____

_____

_____

APPENDIX III-E MODIFIED CHECKLIST FOR AUTISM IN TODDLERS (M-CHAT)

Diana L. Robins M.A., Deborah Fein Ph.D., Marianne L. Barton Ph.D., James A. Green, Ph.D.
University of Connecticut
The full text may be obtained through the Journal of Autism and Developmental Disorder: l, April 2001

PLEASE NOTE: The M-CHAT was not designed to be scored by the person taking it. In the validation sample, the authors of the M-CHAT scored the checklist. If parents are concerned, they should contact their child's physician.

ABSTRACT

Autism, a severe disorder of development, is difficult to detect in very young children. However, children who receive early intervention have improved long-term prognoses. The Modified Checklist for Autism in Toddlers (M-CHAT), consisting of 23 yes/no items, was used to screen 1076 children. Thirty of 44 children given a diagnostic/developmental evaluation were diagnosed with a disorder on the autism spectrum. Nine items pertaining to social relatedness and communication were found to have the best discriminability between children diagnosed with and without autism/PDD. Cutoff scores were created for the best items and the total checklist. Results indicate that the M-CHAT is a promising instrument for the early detection of autism.

BACKGROUND

The M-CHAT is an expanded American version of the original CHAT from the U.K The M-CHAT has 23 questions using the original nine from the CHAT as its basis. Its goal is to improve the sensitivity of the CHAT and position it better for an American audience.

The M-CHAT has been steadily expanding its radius of usage in the state of Connecticut and surrounding New England states. Its authors are still collecting data on the initial study, awaiting final outcomes for sensitivity and specificity after the subjects return for their 3.5 year well-child visit by 2003. The authors have applied full funding of an expanded study on 33,000 children. The M-CHAT tests for autism spectrum disorder against normally developing children.

M-CHAT SCORING INSTRUCTIONS

A child fails the checklist when 2 or more critical items are failed OR when any three items are failed. Yes/no answers convert to pass/fail responses. Below are listed the failed responses for each item on the M-CHAT. Bold capitalized items are CRITICAL items.

Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum. However, children who fail the checklist should be evaluated in more depth by the physician or referred for a developmental evaluation with a specialist.

1. No	6. No	11. Yes	16. No	21. No
2. **NO**	7. **NO**	12. No	17. No	22. Yes
3. No	8. No	13. **NO**	18. Yes	23. No
4. No	9. **NO**	14. **NO**	19. No	
5. No	10. No	15. **NO**	20. Yes	

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes	No
2.	Does your child take an interest in other children?	Yes	No
3.	Does your child like climbing on things, such as up stairs?	Yes	No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes	No
5.	Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	Yes	No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes	No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes	No
8.	Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling, or dropping them?	Yes	No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes	No
10.	Does your child look you in the eye for more than a second or two?	Yes	No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes	No
12.	Does your child smile in response to your face or your smile?	Yes	No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes	No
14.	Does your child respond to his/her name when you call?	Yes	No
15.	If you point at a toy across the room, does your child look at it?	Yes	No
16.	Does your child walk?	Yes	No
17.	Does your child look at things you are looking at?	Yes	No
18.	Does your child make unusual finger movements near his/her face?	Yes	No
19.	Does your child try to attract your attention to his/her own activity?	Yes	No
20.	Have you ever wondered if your child is deaf?	Yes	No
21.	Does your child understand what people say?	Yes	No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes	No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes	No

@ 1999 Diana Robins, Deborah Fein, & Marianne Barton

APPENDIX III-F TOY / EQUIPMENT LENDING LIST

Month:				
Consultant:				
	Date Out	**Item**	**Family**	**Date Back**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

SECTION IV HOME VISITS

INTRODUCTION

An Infant Development Program Consultant has a unique role to play within the broad spectrum of health, education and social services available to families with infants at risk or with developmental delay. This role relates to their relationship with a family within the family home, as well as the referring and coordinating role they may assume with the family and other professionals who are or should be involved. Another unique aspect of this role relates to their concern for the overall growth and development of the child within his/her family. This takes into consideration the parent-child interaction and recognizes the importance to the family of strong community support. Discussions of roles and responsibilities of Infant Development Program staff and families should not be confined to the initial home visit but should be clarified on an ongoing basis with the family.

Home visits allow a much freer and generally more productive flow of information than do environments which are traditionally the professional's domain (e.g. hospitals, clinics, classrooms). Families may feel more confident to share information, the infant more likely to be rested, relaxed and more secure, and the staff less likely or able to retreat into the traditional role of professional "expert" which parents have stated inhibits productive interaction.

Parents who have received home visits by Infant Development Program Consultants have stressed the importance of certain qualities in staff which contribute to productive interaction. These qualities relate to both personal and professional characteristics. In brief, the personal qualities include a caring and supportive manner, genuine concern for the child and family, and a positive attitude to the child and family. Professional characteristics include knowledge of child development and other resources and willingness to share this information, and inclusion of family members such as fathers, brothers/sisters, grandparents in discussions and program activities for the infant.

The following materials on family-centred care and the home visiting guidelines have been prepared and are based on prioritized input from Infant Development Program staff and families who have received service from Infant Development Programs.

PRINCIPLES FOR WORKING WITH FAMILIES IN INFANT DEVELOPMENT PROGRAMS

Within a framework of family-centred care the following principles are fundamental to the philosophy of the Infant Development Program in British Columbia. Staff employed in Infant Development Programs must subscribe to these principles and ensure that all Infant Development Program services conform to these principles as they relate to the infant, the family and the Infant Development Program staff.

The Family

1. Parents know their child best.

2. The family has the right to services that will assist them to live as normally as possible.

3. The parents are the chief decision makers and advocates for their child.

4. The family's needs and perception of needs will be recognized and respected.

5. The family will be encouraged to perceive the importance of their role with regard to their children and provided with tools to facilitate this.

6. Parents will be provided with channels to assess their involvement with the program, opportunities to make policy recommendations and to monitor the overall program.

The Infant

1. The infant has a critical need for an accepting, facilitating family.

2. The infant has the right to available and appropriate medical, educational and social services regardless of degree or multiplicity of disability.

3. The infant has the right to participate in a full range of social and community opportunities as would any infant.

Staff

1. Staff will respect the family, child and lifestyle at an individual level and in all matters relating to confidentiality.

2. Staff are aware of their role and responsibilities to the family and are aware of the limits of their role and responsibilities.

3. Staff will support involvement of other professionals, assist in referral to appropriate resources and provide information that will be of assistance to the family.

4. Staff will have knowledge of principles of normalization and commitment to those principles.

5. Staff will be caring but professional in attitude.

PRINCIPLES UNDERLYING FAMILY-CENTRED CARE

Infants and toddlers are uniquely dependent on their families for their survival and nurturance. This dependence necessitates a family-centred approach to early intervention.
Programs should define "family" in a way that reflects the diversity of family patterns and structures.
Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is a cornerstone of family-centred early intervention.
Early intervention systems and strategies must honour the racial, ethnic, cultural, and socio-economic diversity of families.
Respect for family autonomy, independence, and decision making means that families must be able to choose the level and nature of early intervention's involvement in their lives.
Family/professional collaboration and partnerships are the keys to family-centred early intervention and to successful implementation of the IFSP process.
An enabling approach to working with families requires that professionals re-examine their traditional roles and practices and develop new practices when necessary -- practices that promote mutual respect and partnerships.
Early intervention services should be flexible, accessible, and responsive to family-identified needs.
Early intervention services should be provided according to the normalization principle -- that is, families should have access to services provided in as normal a fashion and environment as possible and that promote the integration of the child and family within the community.
No one agency or discipline can meet the diverse and complex needs of infants and toddlers with special needs and their families. Therefore, a team approach to planning and implementing the IFSP is necessary.

From Guidelines and Recommended Practices for the Individualized Family Service Plan, Second Edition, Association for the Care of Children's Health, Bethesda, MD 20814, 1991

TWO CONTRASTING MODELS OF EARLY INTERVENTION

Infant Development Programs have moved from a traditional `deficit' model of early intervention to a social systems model. Differences between these models as defined by Carl Dunst are as described in this table.

Traditional Model Components Characteristics	**Social Systems Model** Components Characteristics
Deficit **Approach** Differences in behaviour are viewed as deficits and weaknesses inherent in the child, family, and their culture. Intervention focuses on the remediation of deficits.	**Proactive** **Approach** Differences are viewed as variations in behaviour resulting from ecological forces that affect the child, parent, and family functioning. Intervention focuses on strengthening families.
Usurpation Locus of decision-making is with professionals. Interventionists usurp decision-making by deciding for families what is wrong, what course of action needs to be taken, when and how often interventions ought to be done, etc.	**Empowerment** Locus of decision-making is with the family. Interventions empower families with skills, knowledge, and competencies that allow them access and control over resources that can be used to meet family needs.
Paternalism The client (child, parents, family) is seen as having some sickness or pathology seeking the expert advice of the professional who prescribes treatment to alleviate the illness.	**Partnerships** Families and professionals work hand in hand on an equal basis, pooling their mutual strengths in order to devise courses of action that can be taken to meet family identified needs.

From: Dunst, Carl J., "Rethinking Early Intervention", Analysis and Intervention in Developmental Disabilities, Vol. 5, pp. 165-201, 1985.

PROFESSIONAL ATTITUDES AND PRACTICES THAT ENCOURAGE CONFIDENCE IN THE PARENTING ROLE

Can be used for self-reflection for Infant Consultants

Infant Development Programs provide parents with information and support in the parent's home. Although the "home" should be the place where professional and parent "barriers" are least felt, this is not always the case. It is almost as easy for professionals to be as instructive and "bossy" in a home as it is in a clinic or school setting. These points may help you and the parent to examine your relationship and to function more effectively together.

		Some times	Always	Never
1.	Do I allow the parent to feel in control of the visits in terms of			
	• what happens to their child	_____	_____	_____
	• what they are doing?	_____	_____	_____
2.	Although I may provide significant information and skills, do I listen to the parent and respect the fact that they know their child far better than I do?	_____	_____	_____
3.	Am I sensitive to the parents' needs and priorities and respond to what they consider to be important rather than what I consider to be important?	_____	_____	_____
4.	Do I recognize the parents' strengths and try to build on them?	_____	_____	_____
5.	Do I help the parent			
	• to set functional priorities for their child?	_____	_____	_____
	• put these goals and priorities into daily practice?	_____	_____	_____
6.	Is the parent as involved as I am in planning activities for their child?	_____	_____	_____
7.	Do I recognize			
	• the individuality of the parents' interaction with their child?	_____	_____	_____
	• build on those activities they enjoy together?	_____	_____	_____
8.	Do I tell the parent 'why' and 'how' the activities parents do with the child benefits him/her?	_____	_____	_____
9.	Do I give the parent alternate ways to deal with the child so that the parent doesn't feel a sense of failure if something doesn't work?	_____	_____	_____
10.	If the child is particularly unresponsive, do I help the parent deal with this frustration?	_____	_____	_____

Adapted from Bromwich, Rose, with permission, from *Working Together, An Interactional Approach*, Baltimore: pro-ed, 1997

FAMILY INVOLVEMENT AND ACTIVITY-BASED INSTRUCTION

The following are guidelines for family involvement in the Infant Development Program. Activity-based instruction, as defined below, should form the basis of most home programming; recognizing that for some infants and families a more structured behavioral approach may be beneficial.

Family Involvement

- Intervention services promote family's independent functioning
- Family is the primary responsible party
- Interventionist is consultant and resource
- Problems identified, prioritized, and solved if/when family says so

Activity Planning is

1. Engaging and motivating
2. Flexible to accommodate different interests, needs, and ability levels of child and family
3. Functional
4. Process-oriented
5. Child-directed

Rationale for Activity-Based Instruction

- Make best use of routine care-taking and play activities
- Non-intrusive, child-directed approach
- Increase motivation for teaching and learning
- Teach in environment where skills are used
- Assist in acquisition of parenting/care-giving skills

Characteristics of Activity-Based Instruction

1. Emphasis on natural context for learning
2. Goals are embedded within daily activities
3. Child is viewed as actively involved in the learning process
4. Child is encouraged to initiate
5. Sequencing of skills is often based on normal development
6. Structure and sequencing of instruction is variable (i.e., incidental teaching strategy)
7. Environmental arrangement and modelling are primary teaching methods
8. No structured reinforcement procedures - use of logical consequences

Note: The above points were organized by Angela Notari, Early Intervention Program, University of Oregon

Reference: An Activity-Based Approach to Early Intervention; Diane Bricker and Juliann J. Woods Cripe, University of Oregon

INITIAL CONTACT WITH THE FAMILY

1. Referral Source

Collect relevant information from the referral source, using the referral form. Ensure that the infant meets the criteria for eligibility for service and the family is aware of the referral. Further information may be required prior to contact with the family. This may involve one or more of the following to be undertaken by the referral source or Infant Development Program staff.

- Public Health Nurse home visit/possible administration of Ages and Stages Questionnaire to confirm delay or risk
- Contact referral source for clarification if necessary

Guidelines for Inappropriate Referrals

a) For some infants/families, it will be clear that there is a more appropriate community resource for them. The referral source should be requested to direct the referral to this resource.

Examples include:

- preschool/day care for children over age 3
- home program for deaf infants (Lower Mainland)
- Public Health follow-up

b) All other referrals may be discussed at Case Review Committee/at peer file review or at LAC. Keep a file of all inappropriate referrals and review to determine if there is a trend for these it may indicate a need for educating the referral source or increased community education.

2. Does the Family Know They Are Being Referred?

If the family is eligible for service, confirm that the referral source has told the family about the Infant Development Program and determine whether the Infant Development Program is to contact the family or the family to contact the Infant Development Program.

3. Initial Contact with the Family

The caring yet professional approach which families have stressed is important to them should be evident in this initial contact. Initial contact with the family may vary according to individual program characteristics and reason for referral. The IDP is a relationship-based program, all efforts should be made to assign one IDP consultant to a family and minimize change. This consultant makes the initial contact.

4. Points to Cover During Initial Contact

Information that should be shared during the course of the initial contact includes:

a) Introduce yourself and the name of the program.

b) Mention the referral source and that you understand that the referral source has described the Infant Development Program to the family and suggested that you contact them. Ask what the family knows about the IDP

c) Briefly describe the Infant Development Program in relation to family's need for information.

- waitlist / interim support services available as applicable
- home based, regular visits to assist you to help your child
- home visits are free of charge and your participation is **voluntary**
- infants aged 0-3 years who are at risk or delayed in development or have a disability or special need are eligible
- other services which may be provided, such as
  - ❖ opportunities to meet other parents
  - ❖ toy and book library
  - ❖ parent and child group
  - ❖ therapy consultants
  - ❖ parent education
  - ❖ referral to other community agencies / individuals
  - ❖ service coordination

d) Ask if the family has any questions.

e) Offer to make a home visit to meet the family and describe the program more completely to them. Set a time most convenient to family and infant.

f) Set up the date / time for the first visit as soon as possible as parents may be anxious about this initial visit. Explain that you visit other families and that you cannot be precise as to the time that you arrive for this initial visit, but will arrive within 15-20 minutes of the time set. Do not arrive early. As a parent has told us: "Those last 5-10 minutes can be so critical in whether we feel (and look) organized or dysfunctional!"

INITIAL HOME VISIT(S)

These principles apply:

This visit should not be rushed and may take longer than regular ongoing home visits. This visit formally sets the stage for the relationship between staff and family for the course of the program involvement. Major factors that have facilitated successful partnerships with families include:

- acknowledgement and support of the parent's role;
- positive response to the infant;
- supportive, active listening; and
- professional competencies of the Infant Development Program staff.

The following points describe information sharing that should take place during this visit. However, it is important to be sensitive to the amount shared.

1. Introduce yourself to the parents, the baby and other family members who may be present. Describe your background in working with infants and their families.

2. Assure the parents that all information they share with you will be kept confidential and that only with their written permission will information be shared with other professionals, agencies, etc. Explain the consent forms.

3. Outline what you hope to discuss during the visit, including:
   - discussion with the family about the baby;
   - description of the Infant Development Program;
   - priorities for the parent and how the Infant Development Program or other agency may help.

4. Ask the parents what concerns they have about their baby's development and what information they have been given about the baby by others. Record relevant information on referral form, the medical form, and the home visit record sheet. If it seems more appropriate to do this at the end of the visit to ensure ease of communication, leave recording to the end of the visit.

5. Describe the Infant Development Program and the services it provides but only to the degree that will be beneficial. Do not overwhelm them with information. There will be ongoing opportunities to give information. Give the parent the Parent Information Package which should include: the brochure, a fact sheet developed by the local program (which describes the program in detail), other community resources, the program philosophy, and client’s rights and responsibilities. Be aware of literacy level or first language of family.

   Discussion and written material should cover these areas but may be described over the course of many home visits:

a) Who the program serves;

b) Why the program was developed (rationale for early intervention);

c) The role of the parent in relation to:

- their child's development
- Infant Development Program staff
- the Local Advisory Committee.

d) What takes place during home visits, to include:

- activities developed by parents and staff will be incorporated to a large degree into the regular day of the family. Suggestions will be as practical as possible. Goals will be set by the parent and staff which will be based on:
  - parents' priorities and perceptions of their needs and the infant's needs
  - assessments (describe Gesell);
  - staff/consultant suggestions;
- Other services may include:
  - opportunity to meet other parents
  - toy and book library;
  - parent and child group;
  - therapy consultants;
  - parent education
  - referral to other community agencies / individuals;
  - service coordination.

6. Ask the parents, given their concerns and the description of the services offered by the program, what their priorities are and if the program might be of use to them. If the parents wish to participate in the program, go over the Parent checklist or Family Needs Survey or offer to leave for the parents to go over prior to the next visit.

7. Complete a Home Visit Record noting the areas discussed at this initial visit and the areas for follow-up that you will be able to assist the family with prior to the next home visit. e.g. special books, introduction to another family, referral to another agency, etc. Give a copy to the family.

8. Explain that it is very important that other professionals who are involved with the family work together with the Infant Development Program and parents in planning the program. Establish who will receive information on the infant (public health nurse, physician, etc) and have the family sign the applicable consent form, leave a copy with the family.

9. Indicate on the referral form that the Parent Package has been left

10. If possible, arrange the date of the next meeting.

INITIAL VISIT CHECKLIST

SAMPLE

Child's Name: _____ File Number _____

Date of Birth: _____

Briefly review the contents of the orientation package	
Overview services of the Developmental Disabilities Association	
Parents and Caregivers as Partners	
• Highlight Rights and Responsibilities	
• Developmental Disabilities Association Code of Ethics	
• Explanation of Client Files and Access to File Info	
• Family Centred Service Plan / Review	
Review Referral Info and obtain signatures	
Consent for service	
Consent to Obtain / Release Information	
Initial Visit History	
Review the services that the child has been referred to and discuss other referrals	
Answer any questions the family may have	
Leave Orientation Package with the family	
Leave business card	

Name of Consultant providing Initial Visit: _____

Consultant signature: _____

Name of Parent / Guardian: _____

Parent / Guardian signature: _____

Date: _____

INITIAL CONTACT WITH THE FAMILY IN A BIRTH HOSPITAL

The arrival of any new baby into a family precipitates a range of major physical, mental, and emotional responses in parents. If the baby has a disability diagnosed at birth, this adds a tremendous impact to an already emotionally charged experience. Informed counselling, which is designed to alleviate this impact and provide direction to community resources, form. Determine if the family has been informed about the Infant Development Program and should be available to both parents in the birth hospital.

1. Referral Source

As with all referrals, collect relevant information from the referral source, using the referral that staff or a parent will visit the birth hospital as soon as possible after the referral is made. Both parents should have the choice of meeting with an Infant Development Program staff person or a parent of a child with a similar disability. This meeting should be arranged prior to the family leaving the birth hospital.

a) Additional information that should be collected from the referral source will be:

b) How much information, and of what nature, has been shared with the family about the baby? (e.g. Has the Infant Development Program package been given to the family?)

c) Has the family been counselled or requested information as to out-of-home care for the baby? If so, what information and of what nature?

d) How much contact has the family had with the baby?

e) Are the hospital staff, physicians, nurses and social worker collaborating in helping the family? If not, can the referral source facilitate this?

f) Do the physician and other involved hospital staff know that a referral to an Infant Development Program has been made? If not, request the referral source to notify the physician that the family has been referred.

g) Is there support for the family from the extended family or from friends?

h) How does the family seem to be coping?

i) Is the mother in a private room and, if not, can one be arranged for the visit?

j) Request the referral source to arrange a meeting with the parents and/or Infant Development Program staff, at a time convenient to the parents.

2. Initial Visit in the Hospital

Many of the same principles apply as for an initial home visit. However, the immediacy of the delivery and diagnosis in the unfamiliar, alien surrounding of a hospital will generally contribute to a much more emotionally charged atmosphere. The following are issues to consider with regard to a hospital visit:

a) Try to visit the baby in the nursery prior to visiting the parents, unless the baby is in the mother's room.

b) You may be the first professional the family encounters who sees their baby as a baby first and, secondarily to that, as a baby with a disability. It is important to achieve a balance between the extremes of perception of "baby" versus "disability". Over emphasis of "baby" may make the family feel guilty about their response to the disability. Alternately, the family should feel that you have some empathy for the depth of their disappointment and sorrow.

c) All families are different. Whether you have shared this experience with other families or whether you are a parent yourself, you cannot know how this family feels. You may have some understanding of the intensity of the emotional experience, but you cannot know how other factors (background, future plans, etc.) influence their reaction. Respect the individuality of each family and whatever feelings that family may have.

d) You must be an active listener. As a helping professional, you may feel charged with a "sense of mission" and overwhelm the family with information or by a positive response. Listen carefully. Provide information as requested or as you see it needed. Give the parents the opportunity to express fears and concerns they may have. Most importantly, assure the family that you are available on an ongoing basis to them and, as questions arise, they have access to you or to others.

e) Discuss with the family, if they choose, how best to tell other family members or friends about the birth of the baby. How other family members and friends respond will be determined by the manner in which they are informed.

f) Be informed. Parents may have questions relating to a wide range of issues: impact of a specific disability on development; resources for preschool and school age educations; job training and other community resources.

g) If the baby has a diagnosis of Down Syndrome, please use the Family Checklist on Down Syndrome (page 195).

h) If the baby has a condition that you are not familiar with assure the parents that you will work with them to learn more and that you have access to a wide range of “experts” and resources that will guide you and the family over the next months or years. Families need to feel confident that you will be there for them.

FAMILY CHECKLIST ON DOWN SYNDROME

Approximately one child in 700 born in Canada has Down Syndrome. This means that approximately 40-60 infants with Down Syndrome are referred to Infant Development Programs in the province annually. Of course, some communities may have no births for many years, other communities may have many. There is considerable variation. A number of resources and agencies have been developed over the years to inform and to support families with a member with Down Syndrome. It is important that all parents of newly referred infants with Down Syndrome have access to the most relevant and up to date information and support available to them.

The following checklist has been developed to assist in ensuring that families are directed to appropriate resources. It is recommended that all families who have newly identified infants with Down Syndrome review this form with IDP staff within the first month or two of referral to the Infant Development Program.

1. My family has the opportunity to meet or to correspond with another family who has a child with Down Syndrome. Yes _____ No ____

   If no, reason: _____

2. Up to date materials on Down Syndrome have been made available to my family. These include books, magazines, parent to parent articles and videos. Yes _____ No ____

   If no, reason _____

3. My family has been informed about the existence of the Canadian Down Syndrome Society and we have been given an up to date copy of their Newsletter. We have also been directed to the B.C. Down Syndrome Society and our local chapter if one has been set up in our community. Yes _____ No ____

   If no, reason _____

4. The most recent update of the Medical Checklist on Down Syndrome is available to my family and our family physician. Yes _____ No ____

   If no, reason _____

5. The Health Passport developed by the Canadian Down Syndrome Society has been shared with my family and our family physician. Yes _____ No ____

   If no, reason _____

6. My family has been introduced to the Family Support Institute and their newsletters.

   Yes _____ No ____

   If no, reason _____

7. My family has been given information about our local Community Living Association.

   Yes _____ No ____

8. My family has been referred to the Down Syndrome Research Foundation and have the opportunity to participate in their work.

   Yes _____ No ____

ONGOING HOME VISITS

Home visits are the integral component of the Infant Development Program. Parents have stressed how important these visits are to them and their child. Comments from parents regarding aspects of home visits, which were taken from parent questionnaires are found in Verbatim Comments of Parents.

1. General points which should be considered regarding all home visits are as follows:

    a. Prompt arrival, or arrival within a set time period should be standard practice.

    b. The visit should be at a convenient time for the family and infant.

    c. When appropriate, involve siblings in activities or plan a short, special time for them to precede or to follow the work with the infant and parents.

    d. Never take visitors on a visit unless the parents understand the purpose of the visit and agree to have a visitor come to their home. Unless the circumstances are exceptional, never bring more than one visitor to the home at one time.

    e. Frequency of home visits will vary depending on family need, caseload, staffing, etc. and visits will usually average 1 to 1-1/2 hours.

    f. Be an active listener on home visits.

2. During the course of a home visit the following should occur. This will vary to some degree depending on the needs of the family and other factors, e.g. a visit made with a consultant, or administration of Gesell.

    a. Spend a short time re-acquainting yourself. Toys for the infant and his/her siblings may be helpful while you talk with the parent.

    b. Discuss progress as well as concerns that the parent may have encountered since the last visit. Concerns may include clarifying professional advice or challenges parents encounter in following such advice.

    c. Introduce new activities for the child. This may include a new approach to teaching a task which the parent has been working on with the child. Although the Infant Development Program toy library may be a most useful resource for staff and the parent, use materials, if possible, found in the home.

d. All new activities or approaches to teaching a task should be modelled by the staff and then tried by the parent. Parents should not be left with activities that have not been tried out during the visit, to ensure that parents have successful and practical experiences.

e. New activities recommended or different teaching approaches must be recorded during this visit, in duplicate, with one copy left for the parent plus one copy for the child's file. Follow-up suggestions for parent or staff should also be recorded on this sheet. For example,

- *consultant* arranging for another professional to visit
- parent arranging for hearing assessment

f. The consultant can introduce any new information, research, books, conferences, association news, etc. which will be relevant to the family. Families should be offered opportunities to view facilities (e.g. pre-schools), attend parent meetings or to become involved with committees or boards which have mandates related to their child's needs, or their needs.

g. Review the visit and answer any questions

h. Set the date and time of the next home visit.

i. Leave copy of the home visit record.

FAMILY MEMBERS

1. Fathers - Fathers should be encouraged to be an integral part of decision making processes and direct program services involving their children. The effectiveness of intervention strategies is in part predicated on parents in partnership with each other as well as in partnership with staff. Home visits should be arranged to enable fathers to participate on a regular (at least every two months) basis. This may entail some evening home visits and requesting fathers to take some time off from work. Parent meetings, workshops on child development, etc. should also be planned for evenings to enable fathers to attend.

Parents responding to the Parent Questionnaire strongly recommended more involvement by the fathers of children enrolled in the Infant Development Program. Whenever possible, fathers should be present during the initial home visit.

2. Brothers / Sisters - Include brothers / sisters when possible. The age of a brother / sister will be a major factor in choosing the type of involvement. The appropriateness of involvement will, of course, change over time as siblings grow older. It is most important that brothers/sisters do not feel disenfranchised by Infant Development Program staff visits to a sibling. Although feelings of resentment and hostility are common among all siblings from time to time (up to and including adulthood), the special attention that a brother or sister may need (such as Infant Development Program visits) can lead to significant problems within the family. These may occur if brothers/sisters are excluded from participation or made to feel that their needs are of less importance than the infant with a delay or disability. Parental feelings, attitudes and behaviour toward their children are important factors in normal sibling reaction to the disabled child. Parents should be encouraged to communicate at an age-appropriate level with their other children what they are doing and why, with regard to their child who is delayed or disabled. Brothers / sisters should be helped to understand as openly and as honestly as possible the nature of their sibling's problem and special activities should be developed that will enable them to help their sibling develop. Guidelines for involving brothers / sisters that Infant Development Program staff should consider and discuss with families are:

a) Be aware that even very young children sense parental anxiety and may develop unnecessary fears or other emotional responses. There may also be problems if brothers/sisters overhear certain conversations. Remind parents to be aware of this and either modify your discussions with parents if brothers/sisters are present or request visits from time to time when brothers/sisters are occupied elsewhere.

b) For the very young brother/sister (under three years of age), bring special toys on home visits that are age appropriate for the brother/sister. Spend a few minutes talking to the brother/sister every home visit.

c) For the older child (3 years+), suggest a special game that he / she can do with the brother or sister. It is an important concept for children to learn as they also have a significant impact on the development of their brother / sister.

d) Some older children may be interested in making a special toy (e.g. mobile) for a brother or sister.

e) There are a number of books written for children who have a brother or sister with a disability. Most are for children aged five years and up. Parents should have the opportunity to review this material.

f) Issues relating to brothers/sisters are excellent topics for parent meetings and a number of resources have been developed for sibling "workshops" as well.

g) Encourage parents to spend special time with brothers/sisters.

3. Grandparents - Encourage parents to share information such as books or reports on the infant with the child's grandparents. Ask parents if it would be helpful to invite grandparents to visit when you are making a home visit. Parents have said that infant staff have been very helpful in sharing information with grandparents when requested and this has been greatly appreciated.

If the infant has a disability, grandparents need sustenance and guidance for their new role just as much as parents do. Because grandparents are once removed from an immediate or ongoing crisis, it is often easier for them to react than it is for parents. Our culture makes grandchildren a "reward" for grandparents for their hard work in getting their family launched. A child who is disabled may present a partial denial of this reward. Reactions of grandparents can present real problems for parents, who may be in need of comfort and support from the grandparents but end up spending a great deal of time and energy supporting them.

Grandparents need to be given the same straight-forward types of information as parents do and this may enable them to:

- provide support to the parents of the child
- help out the parents in practical ways
- help parents put problems into perspective (this may be easier from grandparents because they are not embroiled in the day-to-day problems)
- help other family members including other grandchildren respond positively to the child with a disability

THE GESELL OR OTHER FORMAL INFANT ASSESSMENT

A. Information to be shared with the parent prior to administration of the Gesell

The Gesell Assessment should be explained to the family during the course of the first home visits. If the family agrees to its use, it should be administered within two months of referral to the program. The following points should be covered in discussing the Gesell with the family:

1) The Gesell is done to give us an indication of where a child is functioning in different skill areas. This is important because it provides us with guidelines for planning a program for the child. Because it is administered at regular intervals, it provides a record of the child's development over time.

2) The Gesell is a standardized tool like the Ages and Stage Questionnaire and needs significant modification for children with certain disabilities. It is not perfect. It cannot predict how well a child will do in the future. It is not an I.Q. test.

3) When writing developmental reports, which are based in part on the Gesell, we use information from it to outline skills the child has acquired or is beginning to acquire in these areas: gross motor, fine motor, language, adaptive and personal / social skills.

4) These reports are addressed to the family and, with permission from the family, copies are sent to other involved professionals (e.g. the child's physician). Parents decide who should receive them.

5) A favorable setting for the administration of the Gesell should include these points:

- the setting is familiar to the child, e.g., home
- the child is well rested, alert and comfortable
- there are no distractions (TV, radio, *siblings*)
- both parents are present, if practical or possible

6) If appropriate, give parents a copy of A Parents' Guide to the Gesell Assessment (page 233).

7) Discuss the above factors with the parents and answer any other questions which may arise. If parents choose that the Gesell not be done on their child, continue to use a developmental checklist for program purposes and report writing.

B. Home visits where the Gesell is administered

1) Briefly review information previously shared with the parents about the Gesell and go over the assessment form with them. Answer any questions that may arise. Assessments can be anxiety-producing for families and parents have stressed that this is particularly true if they are in the process of accepting the child's delay. It is very important for the child and the family that this be a relaxed time and that the child is never pushed to perform.

2) Explain that we will be reviewing abilities that we know the child has or might have. We will also review abilities that we know the child doesn't have to make sure we get a good picture of the child's development. Stress that this is not a "failure" and that you will be explaining each item (in a low key way) as you go along.

3) Explain to parents that each child should try the activities on his/her own before being assisted.

4) Create the necessary environment - no distractions, etc.

5) During the course of the assessment, describe quietly what you are doing, what is expected of the child and the child's response to the task. It is important to include in this discussion the wide ranges of ages at which children acquire certain skills (e.g. although many children walk between 12 and 15 months of age, some start earlier and some quite a bit later).

6) When the assessment is completed, go over the recording sheets with the parents. You may wish to state that as a result of a particular lag in one area, further assessments might be helpful (e.g. by speech and hearing clinics).

7) If the parents feel that the child can do a certain task which he/she didn't during the test, review that item later, or at the next visit. Sometimes the item tested may be representing a different skill from the one the parents may think is being tested, so make sure that the reason for the item is well understood by the parent.

C. Frequency of Assessment

Assessments are done for the benefit of the family and are recorded in a way which is easily understood by the family. Assessments can be formal (e.g. Gesell) or informal in nature. Type and frequency of assessment is determined by the family in consultation with their Infant Development Consultant, with a written report expected every 3-6 months, unless otherwise specified by the family. The Home visit record which is left with the family following every home visit serves as an ongoing assessment of the infant’s development and progress and includes activity suggestions relating to developmental goals.

If properly documented as a report, a progress note can serve the function of a report. . This information can be used in the family service plan.

Administration of the Gesell assessment is an on-going learning process. Attending Gesell training at Provincial In-services as well as dialogue with Regional Advisors and other consultants are important.

REPORT WRITING

Each report is an individual look at an infant. A person reading the report should be able to get a clear, accurate picture of the infant, his family and his environment. The report should include referral and history information, a positive account of the infant's development, a description of the needs of the infant and family, services available to the infant and family and the recommendations or future goals developed by the family and Infant Development Consultant.

Reports for parents are written at regular intervals as requested by them. Generally, these reports are based on the Gesell or other assessment, or on information that relates to the development of the infant. Recommended frequency of administering the Gesell Assessment is four months for infants under one year, six months for children over one year. Typically, a report based on a Gesell or other assessment will include:

1. Heading
    a. Addressed to the child's parents
    b. Name and date of birth of child
    c. Chronological age of child and date Gesell administered
    d. Date the report was written
2. Background Paragraphs
    a. Reason for referral to the Infant Development Program
    b. Referral source
    c. Date of referral and length of time in the Infant Development Program
    d. Parent/professional concerns, in addition to the reason for referral
    e. Disposition, general health and other impressions of the child
    f. Parent involvement with the child and with the Infant Development Program
    g. Consideration for the relationships the infant has within his/her family and the broader community. Assessment of interactions with brothers/sisters, peers and adults in a variety of settings may provide very important information.
3. One or two paragraphs for each of the developmental areas assessed, to include:
    a. Gross motor, fine motor, adaptive, language, personal / social or other appropriate areas such as play and peer interaction
    b. Range of ages for acquired or emerging abilities (optional)
    c. Description of behaviours assessed to include abilities acquired or emerging
    d. Description of behaviours not yet present (optional)
4. Summary paragraph: general impressions of the child and the family.
5. Recommendations: in list-form, describe:
    a. Behaviours which parents wish to focus on in developing program activities. These will emphasize the strengths which are evident.
    b. For each behaviour, goals should be described and a goal sheet should be attached to this report.
    c. Other services, resources or further assessments which the infant and/or family could utilize during the next six months should be listed.

Distribution
When a draft report is written, the Infant Development Program staff should hand deliver this report to the parent on the next home visit. Both the staff and parent should review this and ensure that there are no inaccuracies and that the information is clear, prior to sending it to the other involved professionals. Because professionals involved with families often change over a six month period, the parent and staff should review who should receive copies each time a report is written and update the consent form.

Reports written when Gesell is not used as an Assessment Tool:
Although the Gesell is typically used for infants referred to Infant Development Programs, it may not be appropriate for all infants and/or families. Infants with multiple disabilities, some neurological disorders, or single-sensory-impairments may be unnecessarily penalized by this assessment, even when administered with exceptional care. Parents may feel that comparisons to a normal population are unfair, unnecessary, or may present such a negative picture that their child's strengths are not accurately reflected. It is important to remember that all standardized assessments look at only certain aspects of development. Affection, response to caregivers, and temperament are a few dimensions out of many that the Gesell and most infant assessments do not address. These other dimensions may be much more appropriate measures for parents and staff to address.

Reports written that are not based on the Gesell should be based on an assessment of the abilities the child has, using as a resource, materials such as "A Comprehensive Program for Multi-Handicapped Children" which is non-age referenced.

The AEPS is useful. Consult your Regional Advisor or the Provincial Office for more information on assessment selection and implementation.

Reports for children who are developing at a very slow pace are as important to families as reports done on children who are developing more quickly. Every child makes progress at his or her own rate. It is the responsibility of staff and parents to sharpen skills which facilitate the measurement of progress in children. For parents of children who are developing very slowly, reports over time do indicate progress and provide reinforcement for their efforts on behalf of their children.

Format of Report:
The format will be similar to reports based on Gesell. Developmental checklists or other resource materials used to determine abilities will be identified. Unlike reports on Gesell, however, one area such as feeding, auditory or visual response may be emphasized if skills in other areas are very slow to develop.

Summary
Parents have indicated very strongly that written reports are very helpful for these reasons:

- reference for planning future activities
- record of the child's progress over time
- written material to share with other family members
- ensures other professionals are kept up-to-date on the child's development.

REPORT FORMAT

Date: _____

_____ Infant Development Program

Report on: (Child's Name) _____

D.O.B: _____

Parent's Name: _____

Address: _____

Introduction Includes:

- When the child was referred to the Infant Development Program,
- Who referred the child?
- Why the child was referred
- Pertinent birth or medical information
- Services that are involved with the child
- When and where who assessed the child, and who was present
- Child's response to the assessment process
- Adaptations made if any

Assessment Tool:
Gesell Developmental Schedules administered (1980 revised edition).
Age at Assessment: Chronological Age / Corrected Age

1. Gross Motor Skills

Refers to the large muscle skills necessary for such activities as rolling, crawling, walking, running, and jumping.
Present Skills: Age Level

2. Fine Motor Skills:

Refers to small muscle hand skills necessary for grasping, releasing, and manipulating objects.

Present Skills: Age Level

3. Adaptive Skills:

Refers to the way a child plays with toys and objects and what that tells us about his thinking, organizing and understanding of the world.

Present Skills:

- Awareness and Visual Attention: is the ability to use the eyes to focus on and track objects.
- Eye hand coordination: is the ability to perceive that an object is separate from the child's body and that he/she must do something to get it. Moves from look-reach-contact-grasp-manipulate explore.
- Functional Asymmetry: is the ability of the hands to work independently.
- Awareness of Large vs. Small: is the preference for small over large objects.
- Relational Play: is the ability to utilize two or more objects in play.
- Object Permanence: is the ability to recognize that an object still exists even when it can no longer be seen.
- Visual Form Perception: is the ability to recognize and discriminate various forms and shapes.
- Spatial Awareness: is the ability to recognize and create forms in a vertical or horizontal dimension and eventually combine the two.
- Problem Solving Skills
- Short Term Memory and Listening Skills

4. Language Skills:

Receptive language refers to the ability to understand the meaning of spoken language.

Expressive language refers to the ability to use sounds, words, and gestures to communicate with others.

Present Skills: Age Level

5. Personal-Social Skills:

Refers to social communicative skills, play skills, and self-help skills.

Present Skills:

Play:

Social/Communicative:

Self Help:

- Feeding:
- Dressing:
- Toilet Training:

Summary
A recap of the child's age and functioning level in each area of the development

(i.e.: At the chronological age of _____ months Ben is functioning developmentally at the following levels:)
Gross Motor Skills:

Fine Motor Skills:

Adaptive Skills:

Language Skills:

Personal-Social Skills:

- A general statement regarding development (i.e. Ben is making steady progress All skills are within the expected range for his age with the exception of his expressive language skills which are at the six month level at this time).

- Outline services that will be continued or a new service that the child will be referred to.

- Outline IDP involvement frequency of visits, playgroups, etc. State when the next assessment may take place.

- Mutually agreed upon goals for the family/child (you may include these on a separate sheet for the family).

- State where you can be reached if there are questions.

IDP Consultant's Signature _____

Consultant's Name and Title: _____

cc: List all people who will receive copies of this report

HOME VISITS WITH THERAPISTS / PROFESSIONALS

Areas in which other professionals are involved in Infant Development Programs include: the Local Advisory Committee, the Case Review Committee, parent meetings, home and group visits. The role of professionals in various aspects of the Infant Development Program should be discussed with the family during the course of the first and subsequent home visits. As well, written information that describes therapy services (e.g., the fact sheet on the program, the program brochure, etc.) should be shared with the family during these discussions. The role of Infant Development Program Consultants as generalists, in respect to therapy services, should be understood by the family. Some therapists (e.g., physiotherapist) review, screen, or assess all infants involved in Infant Development Programs. Other therapists (e.g., speech and language pathologist) are involved when the Infant Development Program Consultant, family, case review committee, and/or the child's physician feel that it would be beneficial.

1. When it is felt that input from a therapist would be beneficial, this should be discussed with the family. Be specific as to the nature of the therapist's input, how this may benefit the child, and how the Infant Program may be modified, revised or reinforced by this expertise. Ask permission to bring the specified therapist on a home visit.

2. Explain to the parent that you will need to share some information about the infant with the therapist prior to the visit. Request permission to share the Gesell Report with the therapist and have the confidentiality form signed, if the parent agrees. If the parent prefers, the parent may share this with the therapist on the visit and the release of information is not an issue. Give the parent some information on the therapist, background with the Infant Development Program, or other agencies, etc.

3. No information is to be shared with the therapist which does not have a direct bearing on the welfare of the child and family. Examples of information that should be shared are:

- Gesell/Report (which includes date of birth, diagnosis, etc.)
- other information relating to developmental status in area which therapist will work
- current program/activities for the infant
- infant's response to program
- information relating to the family which is essential to the visit

If the therapist needs more information than you feel is essential to the visit, ask him/her to ask the parent for this information.

4. On the home visit the Infant Development Program Consultant will record suggestions made by the therapist with one copy for the parent and one for the infant's file. These written suggestions will be reviewed by the therapist when completed to ensure that they are accurate. All suggestions should include:

- a clear description of the activity
- the purpose (goal) of the activity
- realistic guidelines for carrying out the activity (numbers of time/day)
- how to modify the activity if the parent or child has difficulties
- how to determine when the purpose (goal) is achieved

These suggestions should appear under the name of the therapist to establish under whose authority they were prescribed. Ask the therapist if there will be a written report and then ask the parent who should receive copies.

5. Professionals vary in ability to work with families. Some have never worked in this milieu and may have difficulty initially. It is the Infant Development Program Consultant's responsibility to monitor and facilitate the situation so that the family and child receive the maximum assistance from other professionals.

HOME VISITS WITH A VISITOR

Inclusion of a visitor on a home visit will, in varying degrees, affect the interaction between the Infant Development Program Consultant, parents and infant. Unlike therapists, visitors generally do not contribute information that would be of help to the family or IDP staff. However, for new IDP Consultants, students on practica or visitors from other programs, home visits provide the most effective format for learning about the Program, its aims and objectives, parent involvement, etc. New IDP Consultants and students, (i.e. medical students, nursing students, early childhood educators, etc) who will be working in some professional capacity with families involved in Infant Development Programs should have opportunities for home visits. Some families are keen to have opportunities to talk to new Consultants or students about their experiences as they are aware that this input can have a significant impact on future professional practices.

When a family has received home visits over several months, Infant Development Program Consultants should inquire if they would be interested or willing to have a visitor make a home visit. A list of families who would agree to this should be kept by all programs and updated regularly. A consent form for visitors should be signed by the family.

The following guidelines for visitors should be shared with the visitor prior to the visit.

1. Is this home visit necessary? Would written information or review of videos provide the necessary information.

2. If a visit is necessary, ask the family's permission. Explain who the visitor is, why they wish to go on a home visit, where they are from, etc. Ask the family if they would be willing to answer questions the visitor might have.

3. Respect the family's wishes regarding visitors. The needs of the child and family, including the right to privacy come first. If the visitor wishes to take notes, parental permission for this must be requested and such notes reviewed by parents at the end of the visit.

4. When a visit is arranged, tell the visitor who you are visiting, why the child was referred, and the program set up with the family. Confidentiality regarding family problems or other concerns must be maintained.

5. Make it very clear to the visitor that they are guests of the family. State whether or not they are free to ask questions. Request the visitor not to interrupt or distract the family/child during the activity review, etc. During the visit, include the visitor when appropriate.

6. Follow up the home visit with a telephone call to the family, and to thank them and to answer any questions they may have.

SPECIAL CIRCUMSTANCES

There are many circumstances in the lives of families that must be considered by IDP Self-reflective practice is required to deal effectively and professionally with some of these issues.

It is important to remember that SES and educational background of the parent may be more similar than different although the family may be from a different culture.

FAMILIES OF DIFFERENT CULTURES

To make generalizations about different cultures is dangerous and unfair. However, some general guidelines can be developed that may assist in working with families whose values and attitudes may be different from yours.

1. Be aware that the family may have a totally different way of looking at things than you do.

2. Examine your own biases and prejudices and realize that you probably do not understand the rationale for their attitudes and practices.

3. Learn as much as you can about the culture. If you are working in a large centre there may be a cultural centre or immigrant services centre that can help. Sometimes churches, temples, mosques, etc. have helpful people available. A social worker or public health nurse with the same cultural background may be of assistance.

4. Be aware that interpreters or workers of the same cultural background may be baffled by your attitude to disability. For example, interpreters may share a family's sense of shame and cannot understand an attitude of acceptance. They may not want to acknowledge that the child has a problem or disability. Make sure that you have the opportunity to discuss the aims and objectives and philosophy of the Infant Development Program with the interpreter prior to the first visit together with the family.

5. When working through an interpreter, speak to the parent (not the interpreter). This may require some conscious effort on your part, but it is essential that the relationship be established with the parent.

6. Try to understand how the family system works e.g. the division of labour in an extended family and who will be working with the child and making decisions about the child.

7. If you are working with another family of the same culture who are coping successfully and who you feel wouldn't mind sharing information with you, you may be able to ask them about customs, attitudes, etc. You may also find getting the two families together may help, but be very cautious about this as there can be many divisions within what you may consider a homogeneous cultural grouping.

8. Ethnicity shapes family attitudes and behaviours. The staff who understand its significance can avoid offending and utilize ethnic characteristics to the benefit of the family and child. Remember too that values and attitudes relating to child rearing practices are culture bound and that successful child rearing practices are found in all cultures regardless of how different one practice may be from another.

9. It is imperative to give the family information that is translated and literacy sensitive

10. Dress appropriately for the family's beliefs and values.

SOCIAL AND ECONOMIC INFLUENCES

1. When Consultants work with families from social and economic backgrounds different from their own, it is important that they recognize and eliminate stereotypes and prejudice.

2. Families of all backgrounds respond to accurate empathy, non-possessive warmth and genuineness.

3. There may be a tendency for families from low social-economic backgrounds to have difficulty verbalizing their thoughts and feelings. These families may benefit from an action-oriented approach from which immediate results can be expected.

4. There may be a tendency for families of middle and upper social-economic backgrounds to mask their thoughts and feelings. Be aware that difficulties may be present even though everything seems fine.

5. A direct, practical approach is appreciated by families from all backgrounds.

PREPARING FOR COURT ON BEHALF OF A FAMILY

At one point or another it is possible that you may be called to court as a witness. See your agency policy on being subpoenaed. Going to court is like going to another country or culture- there are different customs, rules and language.

EVIDENCE

Your file for the child is a "fruit salad" containing opinions, relative language, jargon, secondhand information (hearsay), and facts; but the legal system wants only facts.
DIRECT EVIDENCE = evidence of your senses.

- I saw it
- I heard it
- I touched it
- I felt it
- I smelled it.

Joe Blow, the neighbour, told you he saw… is an example of INDIRECT EVIDENCE which is INADMISSIBLE because of the rules against hearsay.

COURT

Guidelines for preparing for court.

- Review your work and material so that you know the facts.
- Remember the 5 W's: who, what, where, why, when.
- Cite references to support your view: be familiar with the sources you rely on
- Organize your material.

Guidelines for Direct Examination

- Dress professionally
- Speak up; a firm voice conveys confidence and ability
- Take the time you need to answer each question, but do not unnecessarily delay
- Maintain eye contact with the **judge**
- Listen carefully to the wording of each question. Answer only the question asked. Do not give more in an answer than asked.
- Ask permission to refer to your notes to refresh your memory. You must exhaust your memory prior to referring to your notes. Lawyers may want to clarify what these notes are, and when you made them. They may even want to see them and they are entitled to see all notes you refer to.
- Always reply to a question, never refuse to answer.
- Admit if you do not know an answer, the court is not impressed with a know-it-all.

- Stick to the facts

CROSS EXAMINATION

Remember that:

1. Lawyers are doing their job; it's not personal
2. The PURPOSE of cross-examination is to ensure FAIRNESS by looking for weakness in your evidence, so the judge can decide how much to RELY on your testimony. The lawyer looks to see if you will contradict yourself and the technique is, "If you can't attack the evidence, attack the witness".
3. Do not argue, you are not there to advocate a position, but to state the facts as you see them.

Guidelines for Cross Examination

- Lawyers have a list of questions they will ask and the anticipated answers that build and lead to their argument. Be aware of where the lawyer is trying to lead you.
- Use pauses- they interrupt the rhythm of questioning (onethousand, twothousand, threethousand)
- Have questions repeated if you don't understand, or to cause delay if you don't want to answer. Ask the judge for assistance if you are still having trouble with a question. Wait for the judge to say something or the other lawyer to object.
- Ask the judge for water, or a chair, or a comfort break if you need it. You can also do this to delay and interrupt the rhythm of the questioning and to give yourself some time to regroup.
- Bring something to the witness box that you can drop, such as a pencil or note book. You can buy thinking time for yourself by reaching to find it.
- Be in control of your eye-contact
- If you don't know, say so
- If questioning is hostile, treat council as you would any other hostile person: be polite, clear, firm in your position. You always have the choice to respond to the content of the question without reacting to the tone in which it is asked.
- Be yourself. Be human. Be fair. Be seen to be fair. Be truthful. Be open and do not embellish.

Developed by Lynn Krausert, Regional Advisor, Central Region

FAMILIES EXPERIENCING FINANCIAL DIFFICULTIES

The following section was written for this Manual by a former IDP parent, Catherine Lafortune, to assist us in understanding the impact of financial difficulties for parents raising young children with special needs.

The relationship between full fledged poverty, with its corollary conditions of inadequate housing, poor nutrition, lack of education and proactive health care, and health problems of all types is well documented. Experienced IDP Consultants are well aware, however, that a child with a disability, medical problem or serious risk factor may be born to a family of any social class or socioeconomic status.

Perhaps less obvious is the fact that the advent of an infant with any of these needs may have a devastating effect on a family's financial situation. Where the infant needs a lengthy hospital stay, especially in a hospital away from the parents' hometown, travel and hotel expenses can quickly devour a family's savings and/or credit. The infant's care needs may require that a parent leave his/her job temporarily or permanently. Beyond the usual, relatively brief maternity or paternity leave, most working people will not receive any additional paid leave.

Where two parents have been earning good incomes, the loss of one will have significant impact. Where both earn low wages, difficulties will be greatly compounded. For a single parent, Social Assistance may be the only available option.

Recognizing this grim reality, a parent may try to continue working even under conditions of great strain. Meanwhile, the needs—financial, practical, emotional—of any other family members such as siblings or elder relatives, and of running the household, must still be met. Regardless of whether the parent "chooses" the stress of working outside the home when she is actually needed within it fulltime, or the alternate stress of poverty, he/she may feel doubt, guilt, anxiety, anger, and most of all, fear that he / she won't be able to cope. (Ironically, if the family does collapse under the strain, the infant will probably go to a foster parent who will then earn a salary in an amount that could have solved the natural family's financial problems.)

The Consultant, of course, cannot solve these problems but awareness of their existence and legitimacy from the family's perspective, with accurate empathy and a non-judgmental, co-operative approach to solving practical problems will be appreciated by all families. The following suggestions may be helpful:

1. Some parents may be quite candid about difficult financial situations, while for others, discussion of money matters is strongly "taboo". Within a family, one parent might joke about money worries while the other denies that any such worries exist. Recognize that these represent individual differences in coping behaviours for people in a very stressful situation, and do not necessarily indicate "denial" or family disunity.

2. Be aware that a number of the signs which might seem to indicate emotional or psychological difficulties could also be caused by financial stress: complaints of sleep deprivation or insomnia, chronically fatigued appearance, depression, house always a mess, missed appointments or lateness, transportation problems, family arguments, and difficulty in making decisions, especially those involving spending money.

3. The Consultant should not attempt to judge a family's financial status by appearances (size of house, car, etc.). The stereotype of "welfare poverty" has been supplemented by the 1990's phenomenon of displaced professionals, down-sized middle management people, and well-educated but under-employed young adults. All families can benefit from receiving information about available resources of all types, with opportunity to choose which ones may be worth looking into.

4. With the Consultant's encouragement, some families may discover personal resources that can be helpful and empowering. For example, many workers have Extended Medical Benefits plans through their workplaces but have never explored the support these plans can offer in terms of equipment, supplies, and, in some cases, even private nursing care upon the prescription of a physician.

5. Be sensitive to the fact that many families may greet with horror suggestions that they go to Social Assistance ("Welfare"!) or to service clubs ("Charity"!). People who have always worked, even at low-paying jobs, and have never before needed "services", may initially view these alternatives as very humiliating. Where need overrides pride, the application process itself may be intimidating to families with little or no experience in accessing services. In either case, an experienced family or family support organization may be able to help if the family is open to this option.

6. Accepting services from the At Home Program with its Health Ministry assessment process, may evoke a more positive emotional response and be easier for families; as virtually all Canadians use health services, they carry far less stigma. Where children do not meet all criteria for the full Program, they may still qualify for some needed supports; and the application process may introduce the family to beneficial relationships with both Health, and Children and Family Development ministry workers in a positive way.

7. Infant Development book and toy lending libraries are wonderful resources for all parents including those with financial difficulties. Play suggestions, involving household items observable during home visits, along with toys available on loan, will be much appreciated. The benefit of borrowing rather than buying toys, so that they can change frequently to meet the developing infant's changing needs, can be emphasized.

8. Because cultural, family and individual values around discussing money matters are so diverse, it is always safest and most respectful to allow the family to initiate discussion of this subject. By listening sensitively to expressed needs, the Consultant can find opportunities to share information about available resources families may wish to use. The Family Needs Survey (page 143) has items relating to finances so this tool may be used to open discussion in this matter in a respectful way.

FAMILIES EXPERIENCING PSYCHOLOGICAL OR EMOTIONAL DIFFICULTIES

Parents who are experiencing psychological difficulties often will share concerns with the staff because staff are physically accessible and the parents may not know with whom else to speak. The following concerns expressed by parents may require professional psychological assistance:

a) depression which may be accompanied by insomnia or nightmares; suicidal thoughts might be expressed;
b) strong feelings of rejection toward the child with a disability (a factor which may contribute to a) above);
c) indications that family unity is being threatened (comments about significant and continuous arguments; discussion of impending separation and divorce);
d) comments about the considerable difficulty a normal brother/sister has adjusting to the child with a disability;
e) remarks suggesting neglect of the child or physical abuse. If the Consultant suspects neglect or abuse, he/she is required by law to report this to the Ministry for Children and Family Development.
f) indications that the child with a disability is developing psychological problems.

The parents should be dissuaded from seeking the staff's help in resolving any long-standing or significant problems. Staff should:

a) communicate concern, but decline the counselling role;
b) indicate that the problem appears to need psychological attention and that you are not professionally trained in this area;
c) if this is communicated sensitively and in a caring manner, parents may then be able to ask where professional help is available. It is not uncommon for a recommendation to be acted upon months after the referral is suggested;
d) Consultants should have at their disposal the names of community mental health services and private counsellors.

One psychologist suggests the following for parents who subtly imply, or forcefully insist, that the Consultant provide the kind of help needed to resolve major problems:

> "I get the feeling that you are asking me to help you with a problem for which I am not trained. I am pleased that you trust me enough to confide in me, but because I can't be of help to you, I'd like to suggest a few possibilities where you can get assistance from trained professionals. In any event, I'd like to continue to be involved with (child's name) and you. I'd also be interested in knowing how the problem we discussed is coming."
>
> (Adapted from Seligman, 1979, p.172)

This comment communicates several important facts to the parents.

a) Consultant is aware of the problem and the parents' desire to be helped.
b) Consultant knows his/her professional limitations but is concerned.
c) Consultant is willing to help the parents locate an appropriate resource.
d) Consultant wants to continue to be involved with the family, but shifts the major focus to the child.
e) Consultant retains an interest in the situation as an interested friend, not as a counsellor.

WHEN A CHILD DIES

Some children in Infant Development Programs have life threatening conditions or are at increased risk for death due to underlying conditions. Deaths may be unexpected and sudden, as with SIDS Others may be anticipated, as when a child has a terminal illness. There are few, if any, experiences in life as devastating as the death of a child. As an Infant Development Consultant, your own pain at this loss will be a dim echo in relation to the pain the parents will experience. It is very important, however, to acknowledge your pain and loss and work your way through it. Knowledge of bereavement and the grief process may assist you in coming to terms with this loss and your reactions to the death. This is a time when your skills and knowledge may be of great help to the bereaved parent(s) and other family members.

Support to Families when a child dies.
Because we are more distant to the loss than the family or their friends and relatives, we may be in a better position to offer help during the first days following the death. It is important to understand that bereavement itself can be a life threatening condition, and the support offered to the bereaved parent may make a significant difference in his/her eventual recovery. The following guidelines are adapted from material developed by Amy Hilliard Jensen and are available in a more general form through the B.C. Cancer Agency.

1. Get in touch. Telephone. Speak either to the parents or to someone close and ask when you can visit and how you might help. No matter how much time has passed since the death, it is never too late to express your concern.

2. Say little on an early visit. In the initial period before the child's burial, your hugs, your words of affection and feelings may be all that is needed.

3. Support plans to hold the funeral or other symbolic community gathering to mourn the loss and/or to celebrate the life of the child. Sometimes parents are advised not to have a service. Most parents come to regret such a decision. Some have experienced great healing years after the death when such a ritual is done.

4. Avoid clichés and easy answers such as "She had a good life" or "He is out of pain" or "Aren't you lucky she didn't suffer longer?" These statements will not be helpful. A simple "I am so sorry" is better. Do not attempt in any way to minimize the loss.

5. Be yourself. Show your natural concern and sorrow in your own way and in your own words.

6. Keep in touch. Be available.

7. Attend to practical matters or help other family members or friends of the family offer practical assistance to the parents; this might include child care, house cleaning, meal preparation, and funeral arrangements.

8. Encourage others to visit or help. There may be other parents in the Infant Development Program who are involved with the family; assist them to offer support. This might involve scheduling visitors so that everyone doesn't come at the beginning or fails to come at all. If much time lapses, people feel a reluctance to intrude. However, this may be the very time at which a kind word would be helpful.

9. Accept silence. If the bereaved parent doesn't feel like talking, don't force conversation. Silence is better than chatter.

10. Be a good listener. The one thing the bereaved parent needs above all else is someone who will listen and listen without judgment. Accept whatever feelings are expressed. Do not change the subject. Listen.

11. Do not attempt to tell the bereaved parent how he/she feels. You can ask but you cannot know. Even if you are a bereaved parent yourself, you cannot say, "I know just how you feel". Each person's feelings are unique. Learn from the mourner. Do not instruct.

12. Do not probe for details about the death although, for many bereaved parents, discussing the specific details of the death over and over can help to begin to acknowledge the reality of the death.

13. Comfort children in the family. In general it is better for children to be involved in the grieving process rather than to be shielded or protected from it. Even very, very young children understand more than we may believe, and they need support in dealing with the loss of their brother/sister. They also may need ongoing support, as their parents may not be emotionally available to them.

14. Avoid talking to others about trivia in the presence of the bereaved parent. Prolonged discussion of sports or weather, for example, is resented even if it is done to distract the bereaved parent.

15. Allow the working through of grief. Do not whisk away clothing or hide pictures. A bereaved parent may carry around his/her dead child's clothing or picture. The sibling may want to wear the dead child's clothing.

16. Write a letter. Your involvement as an Infant Development Program Consultant with the family may give you a particular perspective on the child and knowledge about the child's development and personality or loving aspects. You may wish to put these memories into writing to share with the parent. Those sorts of remembrances are often read many times and cherished by a bereaved parent, sometimes into the next generation. This may be particularly true for those children who die as a result of serious disabilities and whose value as a person is not shared by other family members or friends.

17. Encourage the postponement of major decisions until the period of intense mourning is over. Whatever can wait should wait. Decisions about disposal of the child's clothes or belongings should be postponed. If necessary and with the parent's permission, those objects may be packed up and stored. Many parents have expressed great sadness in years to come that they have no mementos of their child. Others have been very grateful when friends have stored these objects and, in a year or two, have been able to go back to choose from toys or clothes those that would be of meaning to them.

18. With the parent's permission, as an Infant Development Consultant you may wish to inform the professional community of the child's death. This might include those clinics at B.C.'s Children's Hospital or other services that have seen the child on a routine basis. It is very important that this be done. It is very difficult for parents when they receive letters from professionals or hospitals long after the child's death reminding them of an upcoming annual appointment.

Parental bereavement is a very lengthy process. Experts estimate that it takes between two to seven years before parents recover. Most bereaved parents will agree that 'recover' is not a good word; they are forever altered by this experience. Helping parents to access counsellors or other community support services that will help them through the period of extended mourning is important. There have been many excellent books written that may be helpful to parents. Please see the Resource List in this Manual or speak to the Provincial Advisor.

CHILDREN WITH DEGENERATIVE CONDITIONS

Some children referred to IDPs have illnesses, or degenerative conditions with very limited life expectancy. However, recent medical advances and treatments from a range of paediatric specialists have resulted in many children living longer lives and with greater quality of life than previous generations. We may be involved with families for a long period of time and families have said to us that our ongoing support through the time of their child's illness and following his or her death was very beneficial to them in their coping and in their recovery.

Our role during this time will vary depending on the needs of the family and child. Families have said that they value our 'being there' for them as a trusted and knowledgeable support person. We may help them to navigate the challenges of coordinating multiple care providers and health care personnel. We may help them navigate the painful physical and emotional realities of caring for a child with a terminal illness or degenerative condition. We may also be of great help by providing their child with ongoing developmental encouragement and play activities that are fun and engaging for the child and family. We can support their hopes for their child and a focus on living.

Supporting families through the illness and death of their child is very difficult, particularly if staff have not worked out their own issues of loss and death. It is highly recommended that IDP consultants or others involved with the family have opportunities to share their feelings with colleagues in peer supervision or other similar group situations.

HELPING YOUR INFANT / TODDLER (0-3 YEARS) WHO IS GRIEVING THE DEATH OF A LOVED ONE

This resource sheet is intended for you and your family/friends as you support your infant/toddler through the grieving process. It is recognized that this may be one of the most difficult times in your family's life and it is hoped that some of the following suggestions will help you and your child as you grieve together.

Infants and toddlers do not yet have the concept that death is permanent. They will likely believe that the person they have lost will be coming back (as they do after taking a trip or sleeping). Even though they cannot fully understand what is going on around them, they will react to the loss. Your child will react based on the closeness of the relationship they had with the person (ie; parent, sibling, grandparent or other significant person). Some examples of your child's reactions may include:

- You may find that your child will be clingier with you and require more attention from you. This is related to a child's need for extra security especially from you (parent), their primary attachment figure. Your child may be afraid of separation from you, especially early on in the grieving process. Young infants who have lost a parent/caregiver will "look" for the person visually in their environment. They might show most of their grief (ie; crying) at bedtime when that person is not there to help them go to sleep-it is at this time that they will most likely remember the smell and voice of their parent, especially their mother. Older infants/toddlers may search and ask for the person, especially as time passes from the death.
- You may also find that your child will have changes in their eating, sleeping and toileting patterns and demonstrate distress by extra amounts of crying, irritability, and appearing withdrawn. Your child may also want to temporarily partake in activities and routines from a younger age such as; drinking from a bottle, wanting you to feed them, playing with toys/items from a previous developmental level.

Some Ideas to Help Your Child Include:

- Offer/provide your child with many hugs and reassurance. Physical contact (i.e.; hugs, stroking their back/arms) will help them feel comforted and secure.
- As much as possible, provide a consistent daily routine. This will help your child feel a sense of security in their world. For an older infant/toddler, you may want to explain what will be happening in their day in small segments such as, "first breakfast, then we will play outside", "we will go in the car to grandma's, then eat lunch". For some children, showing them a photo of what they will be doing/seeing along with telling them can help them fully process what will be occurring.
- You might find that your child demonstrates the need to carry "security items" with them both in and out of the home-this is okay as it allows the child to feel extra secure and comforted. These items may include; a blanket, doll/bear, an item of the person who has died or any other item they have used for similar purposes.
- It is okay to show your emotions with your child. You may want to tell your child that when you are sad they can hug you. This will allow them to provide you with comfort too.
- Do not be afraid/hesitant to use the word "death/died" with your child. If this is difficult for you right now, allow others to use it with your child. Although young children do not fully understand this word/concept, it properly labels what happened ("Daddy died and we won't see him again, but he loved you so very much") and is a better choice of words instead of "gone to sleep", "went bye,

bye", "on a trip", which can confuse and upset children-they may become afraid of going to sleep themselves or being separated from you.

- Allow opportunities for free/unstructured play. Children, especially young children without a lot of verbal language, will often act out/process their feelings through play. Some toys that can be helpful to have available are: dolls, bears, doll house, "little people" figures, cars and related symbolic play toys. Observe your child's play and see if there is any specific pattern, theme, or expression in it.

- Other expressive play materials can include; play-dough, drawing opportunities, sand play, water activities and other tactile items (with your supervision).
- Your child may also need opportunities to release emotions through active play such as running outside, climbing on a large play structure, throwing, kicking a ball, etc
- Keep memories alive by talking about your loved one, having photos around the house, looking through photo albums and talking about what's happening in the pictures, and allowing your child to carry/play with items of the person who has died.

Most of all, remember that there are people who are able to assist you and your family through this time. Following is a list of places and people who are available to help you:

- Your local Hospice Society (resources, groups and individual grief counselling)
- Grief Works BC (604) 875-2741

  www.griefworks.com
  email: person@griefworks.com
- Your Family Doctor, Faith Community, Community Agencies you and your child(ren) are involved with (ie; child development and drop in programs), friends & neighbours
- Counsellors/Therapists in Private Practice
- Spinoza Bears: special bears and a resource kit provided free of charge by the TB Vets to children experiencing a challenging situation, including grief. To order, contact: (604) 224-7746

  www.spinozabear.org

Some of the information listed in this handout has been adapted from the following sources:

Bereaved Children and Teens; A Support Guide for Parents and Professionals by Earl A. Grollman, 1995
Hospice Care for Children Ann Armstrong-Dailey and Sarah Zarbock Goltzer, 1993
Grief, Dying and Death; Clinical Implications for Caregivers Therese A. Rando, 1984

Prepared by: Kathy O'Connor, BA, ECE-SN
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A Program of: Delta Association for Child Development
British Columbia, Canada Copyright: 2003

Complete reference material info:
Armstrong-Dailey, Ann, & Zarbock Goltzer, Sarah (Eds) *Hospice Care for Children,* Oxford Univ. Press Inc., New York 1993
Grollman, Earl A (Ed) *Bereaved Children and Teens-A Support Guide for Parents and Professionals* Beacon Press, Boston 1995
Rando, Therese A *Grief, Dying and Death-Clinical Implications for Caregivers* Research Press Company, Chicago 1984
*Please note: the above resources were used as references and some of the info/strategies listed in the handout were adapted from the sources. Other info has come from knowledge and previous readings, research and practice. Therefore, I am not citing specific pages in the reference list.

REFERRAL TO ANOTHER INFANT DEVELOPMENT PROGRAM OR TRANSFER TO ANOTHER INFANT DEVELOPMENT PROGRAM CONSULTANT

Consistent support from one IDP Consultant over time is very important for most families. The most common concern expressed by parents with regard to services provided by the Infant Development Program relates to transfer to another program or Infant Development Program Consultant. If a family plans to move or a Consultant plans to resign and a new Infant Development Program Consultant will be working with the family, it is essential that there be discussion with the family about this, and efforts made to make the transfer as smooth as possible. Factors which will facilitate the transfer are these:

1. If the program has more than one IDP Consultant, the Program Supervisor and the Consultant with the caseload to be transferred should decide how the caseload should be divided. Some families might continue with existing Consultants whom they know; others who have been receiving service for some time might be an invaluable resource to a new Consultant.

2. When Consultant changes are to occur within a program, explain this to the family as soon as possible, including the reason for the change (maternity leave, resignation, etc.).

3. Explain to the parent that although there will be differences, in-service, job descriptions, etc., provide Consultants with a similar theoretical approach, philosophy, etc. Describe the background and work experience of the new Consultant prior to the first visit of new Consultant during the transfer process.

4. Outline ways the parent can help with the transfer by discussing the following with the new Consultant.
   - The parent should review their work with their child, their involvement in the IDP, and other agencies. This review could centre around the assessments, reports and home visits in the child's file, and general discussion.
   - The parent should be open with the new Consultant about approaches, attitudes, information and/or support that have helped them in their involvement with the IDP Constructive suggestions to improve service would also be helpful.

5. If possible, make at least two home visits with the new Consultant prior to completion of the transfer of a family.

6. Ensure that all files, Gesell, reports, etc., are up to date and a summary report, including follow-up recommendations, is available for the parent and the new Consultant for each infant and family.

7. If a family is moving and advance notice of this move is given to the Consultant, the following should take place:
   - determine what services are available in the community where the family will be moving
   - discuss these services with the family and determine if possible, which would be the most appropriate for the infant and family
   - application in advance may be necessary for some programs (e.g. waiting list) and, if this is the case and time permits, help the family to apply prior to the move
   - determine with the family what information and of what nature should be sent by the Infant Development Program to the new service and/or what information should be taken by the family to the new service
   - advise the family to request their family physician, paediatrician and/or other involved medical specialists to recommend medical contacts in the new community and to forward medical documents / records etc.
   - advise the family to contact the Infant Development Program on arrival in the new community as well as other services, such as Public Health.

APPENDIX IV-A PARENT ORIENTATION PACKAGE

Within the continuum of services and supports for young Canadian children and their families, there are specialized programs that focus on infants and children who have a developmental delay or who are at risk for delayed development for established, biological and/or psychosocial reasons.

Infant Development Programs in BC provide a range of family-centred prevention and early intervention services and supports for such families and infants. The first Infant Development Program in British Columbia was established in 1972 and there are now 52 programs in the province funded by the Ministry of Children and Family Development. At the provincial level, there is a Provincial Steering Committee, a Provincial Advisor, and Regional Advisors available to support staff and communities in delivering high quality services. Primarily, the programs serve children from birth to three years of age, while a few serve children up to the age of five. Programs are administered by a variety of community agencies. They have evolved to meet the needs of each community and to complement the mix of services available.

WHY EARLY INTERVENTION?

The main goals of the Infant Development Program are to assist family members to a better understanding of their child's overall development, to assist them to feel more confident in parenting their infant, and to empower them to make effective decisions with respect to their child's development.

'Earlier is better' is a focus of the Infant Development Program. Early intervention has a positive impact on the growth and development of an infant with special needs. It promotes healthy parent/infant attachments by helping family members recognize and nurture their infants unique strengths and abilities. Intervention is based on the idea that the child is a child first, and the delay or disability is secondary.

The Infant Development Program emphasizes the strengths and capabilities of the infant and family. The family is the primary focus of services and the home is the centre around which services are built. The aims of our program are to encourage families to make optimal use of available medical, family support and service agencies, to enlarge their understanding of factors pertinent to the overall growth and development of their child, and to acquire skills which will enable them to best encourage their child's development.

If parents are aware of and understand the sequence of development, they are better able to focus on their child’s abilities rather than developmental delays, and are better able to give their child the best opportunities for optimal growth and development.

As the family is a child's most important resource, intervention is best carried out in the home. Activities should fit into the family's daily routine and should be fun and developmentally appropriate for the infant.

The rationale of the Infant Development Program is based on these underlying assumptions: the family is the most important resource for learning, emotional support and encouragement; interventions may be most effective if begun early in the child's life; and that infancy is an important stage of life for learning and promoting positive patterns of interaction between the child, family and community.

PROGRAM HISTORY

The first home-based Infant Development Program in BC was started in Vancouver in 1972 by a committee

of parents of infants with developmental delays and the professionals providing services to them. These parents and professionals were aware of research demonstrating that support and assistance with developmental programming is beneficial to families of young, delayed or disabled children. With support and funding from the Ministry for Children and Family Development (formerly the Ministry of Social Services), similar programs were developed elsewhere in British Columbia.

WHO ARE THE CHILDREN AND FAMILIES WE SERVE?

The Infant Development Program serves children from birth to three years identified as at risk for developmental delay, developmentally delayed in one or more skill areas, or with a diagnosed disability. Programs do not require that children have a diagnosis for families to access our services.

Program Referral Procedure

The Infant Development Program has an open referral policy. Referrals are accepted from parents and professionals such as public health nurses, physicians, hospital therapists, early childhood educators and anyone else who may be concerned about a child's development. Referrals are directed to the Program Administrator by letter, fax or phone call. Involvement in the Infant Development Program is voluntary. If the family is not the source of the referral, they must be informed of the referral and provided with general information about the program.

The Infant Development Program uses a weighted waiting list; some infants are automatically accepted at referral while others might wait until space becomes available. Families waiting for a Consultant to be assigned will receive information as well as an invitation to attend a monthly waitlist consultation session. Parents/caregivers are encouraged to call the program should they have any concerns or require further information regarding the referral procedure, waitlist status, or a specific inquiry about their child.

WHAT WE DO

Services provided by Infant Development Programs are tailored to child and family need and may include:

Home Visits

Home visits are the most important component of the Infant Development Program and the method around which support to the family and programming for the infant is built. Home visits are planned to take place during a convenient time for the family and the baby. The frequency of home visits is discussed with the family and will depend on the needs of the infant and family. Generally, visits are scheduled every two to four weeks, and average one to two hours in duration.

Home visits are a time for IDP Consultants to learn more about the needs and priorities of the family including particular concerns about the infant. Home visits will vary depending on the needs of the family, but usually follow a similar format. During each visit, the family and the consultant review the infant's progress. Successes, problems or new behaviors encountered since the last visit may be discussed and activity suggestions and approaches shared with the family. Information on child development and other community resources may be provided; materials and equipment may be left for the family's use.

Reports

The Gesell Developmental Test Schedule is the standard assessment used in all Infant Development

Programs in British Columbia. It is administered as directed by the family, usually one to two times per year. This assessment, administered by the Infant Development Consultant, gives a developmental profile of the infant and provides the family and the consultant with guidelines for planning a program, as well as a record of the infant's development. A variety of assessments are available for those families who do not find a standardized assessment useful.

All information and reports from the Infant Development Program are strictly confidential. The family and Consultant decide who should receive information regularly and the parent will sign a written consent form.

Family Support
Infant Development Programs can provide opportunities to meet other families who share common experiences and information that may be of support.

Families will be informed of and encouraged to attend workshops, lectures and parent meetings, which will further their understanding and knowledge of child development. In some cases, the Infant Development Program will sponsor or co sponsor workshops with other community organizations. A variety of topics are chosen in response to requests made by families.

Books, Equipment and Toys
The Infant Development Program has a library of books and videos that relate to development in infancy and early childhood~ parenting, specific disabilities, play ideas and other areas of interest. There are also some materials that are written by parents for other parents. These books can be loaned to families involved with IDP. Books may also be accessed through the Provincial Advisor and other agencies.

Specialized equipment and toys can be loaned to families. When necessary, the Infant Development Program can help a family access the necessary equipment through other agencies and assist families to find funding if equipment needs to be purchased.

Rhyme Time / Playgroups
In addition to the above services, the Infant Development Program also offers group activities. Parents and children involved with IDP and other family members are invited to come together for loosely structured play activities that will enhance child development and parent-to-parent support.

During the playgroup, parents have the opportunity to meet and socialize while sharing concerns and experiences in an informal and friendly atmosphere. An IDP Consultant is always present to discuss concerns and offer suggestions when needed. Resource people and materials are also available periodically at the playgroup locations.

The Role of the Parent
Parents may be unaware or uncertain of the importance of their contribution to decision-making about services or programs for their child. It is the responsibility of Infant Development Consultants to encourage the parent's active participation with their child's services at whatever level seems appropriate and to whatever degree the parent wishes to be involved.

Beyond the individual work with their infant, some parents are involved in a variety of other capacities in the administration of Infant Development Programs. At the community level, a parent whose child has been involved with the Infant Development Program may be given the opportunity to participate on Advisory

Committees that monitor and direct programs. Provincially, parents are appointed by the Deputy Minister for Children and Family Development to sit on the Provincial Steering Committee. At this level, they advise on the implementation and operation of the Infant Development Program throughout British Columbia. Families who have a child with special needs are often involved with a variety of community specialists.

Cooperation With Other Services
Infant Development Consultants are generalists, working with the family to design an individualized program to promote the development of their infant, and informing the family of appropriate community resources. IDP Consultants work closely with other community professionals. Since the professionals involved with the family can change over time, the IDP Consultant can assist the family to use new information and coordinate services.

Community Health Nurses
Public Health Nurses provide information in a variety of areas including health care, nutrition, growth and immunizations.

Physicians
Physicians (paediatricians, family physicians and specialists, including those at BC Children's Hospital) provide the necessary medical information and care the infant needs and provide families and the IDP Consultant with important, specific medical information.

Therapists
Consultant physiotherapists are available through the Infant Development Program for gross motor monitoring and follow-up. Children in need of more specialized therapy services such as direct physiotherapy, occupational and speech therapy services will be referred to The Centre for Ability. Some children requiring only speech therapy may be referred to the Public Health Unit. The IDP Consultant may make joint visits with a therapist so that consistent programming can be maintained.

Transitions – Moving Through Life
A transition can be defined as moving from one place or stage of development to another. Change, whether good or bad, can involve stress. Parents of children with special needs may experience greater levels of stress, especially during critical events such as diagnosis of a disability, awaiting developmental milestones such as walking and talking, or moving from one program to another. Families may be relieved to learn that the anxiety they feel during these critical events is common to others. Identifying and understanding the events that may cause stress can help families anticipate and gain a better sense of control.

When the child matures and the Infant Development Program is no longer an appropriate service for him or her, the family may want to look for an early childhood education program. Under the direction of qualified early childhood educators, children have the opportunity to learn language skills, appropriate social skills, cooperation and self-help skills. There are a variety of choices for early childhood education programs for your child. These may include a neighbourhood preschool, family childcare, group daycare centers and more specialized childcare centers. Your IDP Consultant will be able to help you learn more about these choices.

Often children with developmental delays and ongoing special needs require assessments, program planning and continued involvement with other professionals. These needs can be met in a child development centre

or a community setting that provides additional support. The key to a quality program for a child with special needs is an educator who is receptive to involvement with families as well as other professionals. The IDP Consultant can provide families with information regarding observing and evaluating early childhood education programs and suggest several appropriate resources. Investigating several programs will help you choose the best resource for your child. Parents know the most about their own family's and child's strengths and needs, and if you are comfortable with the early education program you have chosen, your child will have an easier time adjusting to and benefiting from the experience.

When a child moves from one program to another, both the family and the child experience a transition. These experiences are different for each family, they commonly include missing the child who is away from home more, dealing with the child's adjustment and their own personal responses to this transition. IDP Consultants can assist families by providing appropriate materials and organizing services in ways to reduce pressures on the family.

The main goals of the Infant Development Program are to assist family members to a better understanding of their child's overall development, to assist them to feel more confident in parenting their infant, and to empower them to make effective decisions with respect to their child's development.

Within a family-centred philosophy, the infant development consultant supports families in the identification of their needs, resources and service requirements. The family's involvement and participation is a recognized key factor in the achievement of successful outcomes. Collaboration across individual professionals and agencies is also key to ensure that family life is strengthened rather than stressed by intervention.

What Do We Do?

We provide an integrated approach to infant development and family-centred intervention that is parent-led and responsive to parent strengths, competencies and priorities. The family is the major decision-maker in a child's life, and the active involvement of the family throughout our involvement is essential to a satisfactory and meaningful outcome.

Through a transdisciplinary approach and in collaboration with other service providers, we aim to provide the highest level of opportunity for the optimal development of the child and family unit. Support is provided within the child's natural environment where the infant development consultant serves many functions.

Staff Training and Expertise

Infant Development Consultants are skilled in providing an effective home-based intervention service. They benefit from continuous staff development opportunities locally, regionally and provincially. A Certificate and Diploma Program in Infant Development are offered through the University of British Columbia (UBC). IDP consultants have training in one or more of the following disciplines: child development; psychology; social work; physiotherapy; occupational therapy; child and youth care; nursing; education; developmental services or other related disciplines.

Infant Development Consultants bring a unique set of skills and abilities to work with families. Their expertise covers knowledge of typical and atypical child development; observational skills; the ability to assess child and family strengths and needs; appreciation of issues related to family dynamics and child-rearing; training with respect to supporting those who experience grief and loss; and advocacy skills.

A family-centred service is promoted to encourage positive parent-child interactions and to promote the infant's optimal developmental progress. The relationship of secure attachment to developmental accomplishment is promoted by the active encouragement of parents to recognize their infant's cues and to respond in ways that foster a sense of security and play.

What are the Outcomes of Early Intervention?

Recent research in the neurosciences provides powerful evidence for the influence of the early years on the children's base for competence and coping skills. These influences may affect learning, behaviour and health throughout their whole life. Infant Development Programs are effective in promoting positive outcomes for the children and families who are nurtured through the child's early years.

To contact your local Infant Development Program,

This Parent Package was developed by Bonnie Barnes and staff of the Vancouver IDP

APPENDIX IV-B RIGHTS AND RESPONSIBILITIES

PARENTS AND CAREGIVERS AS PARTNERS

Our goal *is* to provide you with a quality service. We recognize that parents know their child best and that the family is the greatest resource in providing the best service.

As parents and caregivers of the children we serve, you have rights and responsibilities that belong to you. We have taken the time to outline a few and hope this guide will help you partner with us in providing services to your child.

Rights and Responsibilities:

1. You have the right to information regarding your child and his or her involvement with the Infant Development Program.

    - All records regarding services to your child are yours to view. Every report written for your child's record will be sent to you and shared only with those you have provided consent for. Consultants will be happy to share program information you request contained in your child's record.

    - The right to information also includes being informed about services available to you and your child in the larger community. Please let your Consultant know what your questions are regarding the information you are seeking and she will direct you appropriately.

2. You have the right to service that is supportive of your family routine.

    - We are committed to provide service that is least disruptive to your child and you family. We make every effort to accommodate individual family needs.

3. You have the right to be included in all planning about your child.

    - Infant Development Consultants and parents/caregivers work closely together. You may be asked to participate in a team meeting where all involved with your child have the chance to exchange information. Our goal in working with children and families is to ensure that families remain in control of the decision-making.

4. You have the right to advise the Infant Development Consultant you are working with of any concerns you may have regarding services.

    - Please feel free to speak to the Consultant involved with your family if you have any concerns regarding services. If, however, you do not find this process helpful we have included in this package information regarding the complaints resolution process for the Developmental Disabilities Association. We ask you be informed of this process and follow the appropriate steps.

    - You will also receive parent surveys every six months from the Program Administrator or Department Director to provide feedback regarding a particular program's service. We wish to remain accountable to you and will use your feedback to evaluate our services.

5. You have the right to be informed about current caseload size and capacity and waitlist issues.

- Most IDP Consultants have a large caseload and there is a large weighted waiting list of children.

6. You have the responsibility to advise the Consultant if you are canceling an appointment.
   - Please inform your Consultant if you are cancelling an appointment. Please give as much notice to your Consultant as possible.

Complaints Resolution Process for Developmental Disabilities Association.

1. Contact your IDP Consultant directly regarding your concerns.

2. Contact or write your Consultant's supervisor outlining your concern.

3. Contact the Director of the Child and Family Services Department if you feel that your concern has not been resolved with the appropriate supervisor.

4. Contact the Executive Director or Administer of the _____ if you feel your concern is not resolved.-

APPENDIX IV-C POLICY ON COLDS AND FLU

Our policy on colds, flu and other illnesses

Please remember that some children may have medical complications for which even a cold may be a very serious illness. Because we see other children during the day, we do not wish to expose them to any illnesses.

If you, your child or any other family member, has a cold or the flu (or any other illness such as measles, chicken pox, pink eye etc) please call in advance and cancel your home visit.

Our Consultants are committed to ensuring the health and safety of you and your family, therefore, Consultants will call in advance to cancel any home visits when they too have a cold, flu or any other contagious condition.

Thank you for your understanding.

How to Cancel an Appointment

Please contact your Consultant as soon as you are aware that you are unable to keep your visit.

APPENDIX IV-D A PARENT'S GUIDE TO THE GESELL ASSESSMENT

The Gesell Developmental Assessment was created originally by Dr. Arnold Gesell, who was a paediatrician and a psychologist. Dr. Gesell's work is now being carried on by a small group of physicians who worked with him. The assessment was revised in 1980. We hope the information in this guide will help you understand the assessment and make Gesell reports easier to read.

We administer the assessment for your information, and to help us be more clear about the areas of development in which your child has the greatest need of help. Our reports are written mainly for you, the parents, but they may also be sent with your permission to other professional people -- doctors, community health nurses, physiotherapists, etc. There are a fair number of somewhat technical terms which may appear in a Gesell report, with which you may or may not be familiar. Here are some explanations and definitions:

The Revised (1980) Gesell Schedules:
These are the "score sheets" where we compare your child's behaviour with that of the large number of "typical" infants who were tested originally to find what is average behaviour at different ages. There are no right or wrong responses for your child to make. What we're looking for is the maturity of your child's responses. For instance, given a bell on a table, the average 16 week old baby will immediately look at it and wave her arms. At 20 weeks, she'll approach it and grasp it with two hands. At 24 weeks, she'll grasp it and put it in her mouth, and at 28 weeks, she'll bang it on the table and transfer it from one hand to the other. This emerging awareness of what the bell is, and how it can be used, is shown at 40 weeks on the average, when the baby picks up the bell by the handle, waves it purposefully to make it ring, then pokes her finger inside to investigate the clapper.

Developmental Age:
the comparative age at which the child is functioning. For instance, the child's actual, or chronological age (or age corrected for prematurity), may be, say, 28 weeks. However, when compared with the normative group of children for the Gesell assessment, he may have a developmental age of 24 weeks, or 32 weeks. One point to remember is that these are averages, with variability on either side. For example, the average child takes steps alone at 52 weeks, but many children walk earlier or later and are still in a normal range. The developmental age estimated by the Gesell assessment is not exact, but it can give an indication that a child is delayed, or is average, or accelerated in an area of development.

Adaptive Behaviour:
This is how the child is adapting to the world around her, learning how things work, learning from experience, understanding relationships, and beginning to be able to solve problems. Much of what is assessed in this area is demonstrated by the child with visual connections with people and objects, with eye-hand coordination, and hand use.

Some terms used in the adaptive area which may not necessarily be clear to you:

Object Permanence - the child's underlying mental ability to visualize or conceptualize an object even if it's out of sight. A tiny baby acts as though when she can't see something, it no longer exists. As she becomes more mature, when something disappears, she will look for it, showing she knows that it still exists and must be around somewhere.

Adapting to rotation (with the formboard) The formboard is the "puzzle" with the circle, square and triangular blocks. After the child has responded to the formboard with the circle on the right side, we turn the board around so the circular hole is on the left. At first, he'll try to put the circle back into its original position rather than noticing that the round hole has moved to the other side. At higher

higher maturity levels, he'll correct his error, and eventually see how to change the placement of the blocks at first sight.

Adapting to rotation (with the paper and crayon) imitating a stroke or a circle means watching someone else do it first and then doing it oneself. Copying a stroke is seeing it already drawn and copying it from sight (an ability for a 36 month or higher level).

Colour forms - these are the red forms which the child matches to the red shapes on a sheet of paper.

Geometric forms - the black and white line-drawn forms (square, star, cross, etc.)

Digit repetition. or digit span - the person assessing your child's developmental status may ask the child to repeat some numerals, sometimes two numerals and sometimes three numerals, depending on the child's age. This tests the child's ability to remember, in short term memory.

Gross Motor Behaviour:
Involving large muscles and large movements such as rolling, sitting, creeping, walking, throwing, etc.

Some terms used in reports:

Prone - lying on the stomach.

Supine - lying on the back.

Ventral suspension - holding the baby in the air face down to see if she can lift her head (8 weeks), or her head and legs (16 weeks'), or extend her arms also (20 weeks). This reflects strength, muscle tone and physical maturity.

Muscle tone - we sometimes refer to the feel of a baby's muscles, using terms such as hypotonic, meaning "floppy" with softer or weaker than normal muscle tone, or increased tone, where the baby may be tighter or stiffer than the average infant.

Cruising - walking sideways holding on to a railing or furniture.

Fine Motor Behaviour
Involving small muscles of mouth, hands and feet. The Gesell assessment looks mainly at the child's ability to use hands and fingers. We look at the maturing ability to grasp, and eventually the ability to place and release with more and more control (e.g., dropping toys into a container, stacking cubes successfully, etc.)

The kinds of grasp referred to in Gesell reports, from immature to mature. They are tested with a one-inch cube.

Precarious grasp or ulnar palmar grasp - baby manages to pick up a cube momentarily, with the cube held in the palm on the "ulnar" side of the hand, away from the thumb.

Palmar grasp - held in the palm with five fingers (thumb being used as a finger).

Radial palmar grasp - still held in the palm, but index and middle finger doing the holding, and thumb beginning to oppose.

Radial digital grasp - item held in the tips of fingers and thumb. Thumb in full opposition.

Tested with a pellet:

Raking with a whole hand, then radial raking with thumb and first two fingers. Baby just pulls the pellet towards himself, sometimes being able to get it into his hand.

Inferior scissors grasp - pellet is picked up or attempted to be picked up by pushing it with the thumb

into the side of the curled up index finger. The other three fingers are also quite flexed, not separated from the index finger. A scissors grasp would likely be more successful. It's the same as an inferior scissors grasp, but the other three fingers are just loosely curled, not dependent on the movement or position of the index finger.

Inferior pincer grasp - picked up in tips of thumb and index finger, but with hand and perhaps arm resting on the table

Neat pincer grasp - overhand approach (hand off the table), and picked up with tips of thumb and index finger.

Language Behaviour

We look at language as a whole, including communication skills such as eye contact, smiling, gesturing, signing, etc. We often divide language behaviour into two areas:

Receptive language - what the infant or toddler understands and responds to.

Expressive language - the sounds and words he produces. The term "jargon" is used to mean the "talking" that most children do after they've learned a few words. This jargon is as though the child is talking in sentences or even paragraphs, but sounds like she's speaking in a foreign language. The intonations of language are there, without understandable words.

Personal-Social Behaviour

Includes feeding and dressing skills, social communication and play skills, etc.

A final note

Your Infant Development Consultant will be happy to answer any questions. you have about the Gesell assessment --feel free to ask. We administer these assessments so often that we may forget that some of the items on the assessment or some of the terms we use may have very evident meanings to us, but don't make sense to you, experiencing this for the first time. So we're always happy to discuss or explain what we're doing.

APPENDIX IV-E PARTNERSHIP AGREEMENT

SAMPLE

Service Guidelines:

1. Visits normally take place in your home or in a childcare setting unless otherwise arranged.

2. Depending on family needs frequency and length of visits will be determined with you.

3. If your child is tired or unwell visits can be rescheduled.

4. If possible please phone when you need to cancel or change a visit.

5. Information will be gathered in a number of ways, including assessments, and together we will identify goals and activities to help encourage your child's development.

6. Other services we provide include resource sharing and community and group opportunities.

7. To help plan for your child relevant information will be shared among service providers.

These guidelines may be reviewed at any time.

I understand the above Service Guidelines;

_____ _____

Signature Date

Agreement developed by the _____ IDP

SECTION V LEAVING THE PROGRAM

TRANSITION TO GROUP SETTINGS

When families first become involved with the Infant Development Program the age range served should have been discussed (birth to three), and subsequently reviewed. The following should help the process of transfer. Checklists entitled: When my Child Leaves the Infant Development Program (page 238); Features that Encourage Partnership in Transition (page 239); Preparing for a Conference (page 241); and Choosing a Group Setting (page 243) should be shared with families prior to transferring to another program.

1. Throughout the family's involvement with Infant Development Program, long-term planning and future involvement with other programs should be discussed.

2. Six months before termination of service is planned, discussion of the next step in services should be discussed in detail. This should include the idea of an integrated preschool/daycare setting. Checklists should be distributed to the family at this time. Of particular note, see When My Child Leaves the Infant Development Program (page 238)

3. Begin to visit less often.

4. Arrange visits to preschool settings and, if possible, accompany parent unless it is agreed that the Supported Child Care Consultant will do this. Introduce staff and liaison persons. Support new program and staff - be encouraging about them to the parent.

5. Have an evening where the Supported Child Care Consultant and/or pre-school staff give information to parents. Parents already involved in the pre-school program could be encouraged to attend too, so new parents can meet them.

6. Discuss all the options with the parents and respect their decision. Inform parents of parent organizations or committees they could become involved with and encourage them to continue a teaching role with their child - although this will differ from their role in an infant program.

7. Get forms, etc. necessary and refer to new setting. Ask permission to send along information to new setting (i.e. copy of last Gesell, closing report, etc.). Be supportive of other agency.

8. Once a child is attending a new service the family may be put on follow-up for a few months. Make follow-up visits or telephone to see how things are going. If family are having trouble accepting the new service, or service format, encourage them to discuss their feelings or concerns with their youngster's new teacher.

WHEN MY CHILD LEAVES THE INFANT DEVELOPMENT PROGRAM

1. What community and school experiences would you like for your child after the Infant Development Program?

   _____

   _____

2. What do you need to assist you with these opportunities for your child?

   _____

   _____

3. Complete these sentences with the FIRST thought that comes to mind:
   "It will make a big difference when my child can… _____

   _____

   "As a preschooler, I would like my child to learn how to… _____

   _____

4. Briefly describe your understanding of your child's development:
   Gross Motor _____

   _____

   Fine Motor _____

   _____

   Adaptive _____

   _____

   Language _____

   _____

   Personal / Social _____

   _____

5. How do you feel your child's special needs have affected his/her development?

   _____

   _____

6. Please list your comments and other concerns

   _____

   _____

   _____

FEATURES THAT ENCOURAGE PARTNERSHIP IN TRANSITION FROM ONE PROGRAM TO ANOTHER

When your child has been involved with a program for some time, you may find it quite difficult when it becomes necessary for your child to move into another program. Program changes usually occur when a child reaches a certain age such as three, and moves from an Infant Development Program into a pre-school. It may also happen if your family moves or a more appropriate service becomes available.

Parents have said how hard it is to leave a program for some of the following reasons: they have a close and understanding relationship with the current staff; the child enjoys the program and is doing well. Because the known is generally more comfortable than the unknown, it is very reasonable to feel anxious when program changes are necessary.

However, good preparation for a program change can do much to relieve anxiety and to help you feel more positive about the future. The following checklist may help you identify, with program staff, ways to make the transition easier to handle, and more productive for all involved.

1. **Preparation for Transition**

Have staff encouraged me to look beyond their program to future alternatives?

Yes _____ No ____

Is a range of alternatives identified for me,
(e.g., different preschool programs, primary classes)?

Yes _____ No ____

Have specific features of these programs been clearly described?

Yes _____ No ____

Am I encouraged to tour these programs?

Yes _____ No ____

Are staff prepared to help me make a decision and negotiate
with the program choices?

Yes _____ No ____

Are staff supportive of my decision?

Yes _____ No ____

Are staff supportive of the new programs and personnel?

Yes _____ No ____

Is there an up-to-date report on my child on which decisions can be based?

Yes _____ No ____

2. **Summary Report When a Child Leaves a Program**

Is this report addressed to me?

Yes _____ No ____

Do I control who receives this report?

Yes _____ No ____

Do all relevant professionals involved with my child have the opportunity to contribute to it?

Yes _____ No ____

Are my needs, priorities and observations for my child incorporated into the report?

Yes _____ No ____

Are my family's needs and priorities incorporated into this report?

Yes _____ No ____

If contradictory assessments or information is presented, do the staff and I have methods to deal with this?

Yes _____ No ____

Have I given final approval to this report?

Yes _____ No ____

3. **Staff / Parent / New Staff Communication**

Is it made clear who is responsible for coordinating the transition?

Yes _____ No ____

Are there opportunities for current staff, new staff and myself to meet?

Yes _____ No ____

Are other relevant professionals invited to attend?

Yes _____ No ____

Do I participate in deciding who should attend?

Yes _____ No ____

Is there opportunity for new staff to make a home visit prior to my child entering the new program?

Yes _____ No ____

Am I invited to observe, over time, the new program prior to my child's entry?

Yes _____ No ____

Are my needs and priorities for my child and family respected by the new program staff?

Yes _____ No ____

Are my options for involvement in the new program clearly described to me?

Yes _____ No ____

4. **Follow Up**

During the transition period, if necessary, do former staff interact with the new program to ensure appropriate placement?

Yes _____ No ____

Are former staff available for consultation if problems arise?

Yes _____ No ____

Am I invited to continue to observe my child in the new program?

Yes _____ No ____

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PREPARING FOR A CONFERENCE

During the course of your child's involvement in an education program or at a time when your child is leaving one program to enter another (e.g., pre-school into the school system), formal interviews, conferences, or screenings will probably be set up. Important decisions regarding educational programming or future placement are often made during the course of the interview based on the information presented by professionals involved in the program. Consultants to the program and program administrators may also take part and make decisions.

If you have not had as much experience as a professional in participating in conferences, you may feel awkward, nervous or intimidated by this meeting. Most parents have expressed these feelings about conferences at one time or another. Because these feelings may undermine your self confidence and therefore limit your effectiveness in dealing with the issues and decisions regarding your child, preparation for these conferences may be of benefit to you. Other parents have identified and utilized the following strategies in preparing for and attending a conference or screening.

To Prepare for a Conference

1. If at all possible, both parents should attend conferences. If necessary, request the conference to be scheduled for a time that enables working parents to attend.

2. Be clear about the purpose of the meeting and decisions that will be made.

3. Find out who will be attending and how much contact time they had with your child.

4. Do you know and work co-operatively with at least one of the professionals attending? Will they offer support to you during this meeting?

5. If you are uncertain whether or not you will receive professional support during this meeting, and/or if you feel a little insecure about your ability to present your child's case:

    a. invite a professional who knows you and your child well to attend with you, and / or

    b. invite a parent advocate who has had successful experiences in conferences of this nature. This person may be involved with:

        - education committee in a local Association for Community Living
        - hired parent advocate through an Association for Community Living or Family Support Institute

6. Prior to the meeting, both you and the professional and/or parent advocate should:

    a. inform the chairperson in advance who will be attending

    b. clarify purpose of meeting

    c. decide what materials (if any) to bring

    d. determine what questions should be asked and what information you wish to give:

- about your child and family
- about the present or future program
- about available support services
- about your expectations

During the Conference

1. Your body language will convey a positive message if you:
    - sit down in a relaxed, business-like manner
    - keep eye contact with people you are addressing
    - take the initiative in greeting others and in opening conversations
    - dress appropriately
    - don't physically isolate yourself at the table
    - voice your opinion when necessary
    - carry a folder or briefcase with your materials - organize them in front of you so they are handy
    - take careful notes
2. Your Advocate during this meeting can help you by:
    - asking you questions
    - backing up your points
    - taking notes
    - making sure that information presented by professionals is clear and understood by you
    - reiterating decisions made at the end of the meeting if this is not done by you or the chairman.

Following the Meeting

Write a letter to the chairman of the meeting outlining your understanding of:

- major points covered
- decisions made. Indicate whether you are or are not in agreement.
- dates set for accomplishment of tasks (if any)
- your future role or responsibilities if designated

Sometimes it might be helpful to ask for confirmation in writing or clarification of some points discussed.

WHAT TO LOOK FOR WHEN CHOOSING A GROUP SETTING FOR YOUR CHILD

A. The Staff (Teacher, Caregiver, etc.)

Competent staff should be: warm and responsive with children; encouraging of intellectual growth and development; respectful of the child's individual needs; able to cope with the demands of caring for children; consistent and fair in disciplining them.

1. Do the staff smile and look directly at the children when talking with them, establishing eye-to-eye contact?

   Sometimes _____ Always _____ Never _____

2. Do the staff appear to be physically relaxed with the children when touching, talking with or approaching them?

   Sometimes _____ Always _____ Never _____

3. Do the children appear to trust the staff and freely turn to them for help, information and comfort?

   Sometimes _____ Always _____ Never _____

4. Where do the staff appear to spend most of their time?:

   working with children

   Sometimes _____ Always _____ Never _____

   arranging materials

   Sometimes _____ Always _____ Never _____

   talking with staff in the program

   Sometimes _____ Always _____ Never _____

5. Do the staff guide children in using toys, material or equipment?

   Sometimes _____ Always _____ Never _____

6. Do the staff ask children yes or no questions more often than questions that require creative, thoughtful, or imaginative answers which stimulate children's language and thought?

   Sometimes _____ Always _____ Never _____

7. Do the staff give the children enough time to respond to a question?

   Sometimes _____ Always _____ Never _____

8. Do the staff allow/encourage decision making by the children?

   Sometimes _____ Always _____ Never _____

9. Do the staff have a set routine or schedule organized for the children?

   Sometimes _____ Always _____ Never _____

   Are you pleased with the schedule?

   Sometimes _____ Always _____ Never _____

Does the routine allow for a variety of needs to be met?

Sometimes _____ Always _____ Never _____

10. Do the staff's expectations and treatment differ for girls and for boys?

Sometimes _____ Always _____ Never _____

11. Do the staff label children or gossip about their families?

Sometimes _____ Always _____ Never _____

12. Do you think the staff will be able to meet the special needs of your child?

e.g., individual educational programs, assessments, utilization of available resources: physiotherapy, etc

Sometimes _____ Always _____ Never _____

13. Do the staff seem to be easily frustrated if things are not going right?

Sometimes _____ Always _____ Never _____

14. Do the staff reward and discipline a child?

Sometimes _____ Always _____ Never _____

Are you comfortable with these methods?

Sometimes _____ Always _____ Never _____

Are they consistent with your own?

Sometimes _____ Always _____ Never _____

Are expectations realistic for the developmental age of the child?

Sometimes _____ Always _____ Never _____

15. Is the staff's talk with the children heavily sprinkled with DOs and DON'Ts?

Sometimes _____ Always _____ Never _____

16. Do the staff immediately mediate potentially explosive situations such as fights over toys, name calling, or physical aggressiveness?

Sometimes _____ Always _____ Never _____

B. The Environment

A program's environment includes both the interactions of people and the arrangement and organization of space and materials.

1. Are there too many children in the group?

Sometimes _____ Always _____ Never _____

2. Do the children appear to be comfortable and free with other children in the group?

Sometimes _____ Always _____ Never _____

Or are there numerous fights and disturbances?

Sometimes _____ Always _____ Never _____

3. Do the children encourage one another, appear to play well with others in the group, work co-operatively among themselves?

   Sometimes _____ Always _____ Never _____

4. Small groups and/or individual adult attention are very important to young children.

   Sometimes _____ Always _____ Never _____

   Are there enough qualified people so that the individual needs of your child will be met?

   Sometimes _____ Always _____ Never _____

5. Check the following physical features:

   Sharp edges on furniture?

   Sometimes _____ Always _____ Never _____

   Wall plugs covered, and extension cords not overloaded?

   Sometimes _____ Always _____ Never _____

   Detergents, medications and sharp instruments out of reach? Ask!

   Sometimes _____ Always _____ Never _____

   Stairs and low windows adequately protected?

   Sometimes _____ Always _____ Never _____

   Sufficient lighting and adequate cleanliness?

   Sometimes _____ Always _____ Never _____

   Outside play areas safe from traffic?

   Sometimes _____ Always _____ Never _____

   Do staff have basic knowledge of first aid (CPR)?

   Sometimes _____ Always _____ Never _____

   Are there procedures for emergencies?

   Sometimes _____ Always _____ Never _____

6. Is there enough space for the number of children?

   Sometimes _____ Always _____ Never _____

   Is it divided? Is there an outdoor play area?

   Sometimes _____ Always _____ Never _____

7. Is furniture and equipment arranged in such a manner that your child can crawl, walk, and explore freely?

   Sometimes _____ Always _____ Never _____

8. Are there spaces in the setting for children to work or play quietly and actively with materials and equipment? A variety of needs being met at the same time?

   Sometimes _____ Always _____ Never _____

9. Are there adequate areas and facilities for children to rest and sleep?

Sometimes _____ Always _____ Never _____

10. Are there special areas for a variety of activities: blocks, reading, dress up, arts and crafts? Are the potentially noisy and active areas - blocks, jungle gyms, housekeeping corner - separated physically from quiet areas - reading, puzzles, art centres?

Sometimes _____ Always _____ Never _____

11. Sufficiency of materials:

Are there adequate materials to satisfy the needs of the group?

Sometimes _____ Always _____ Never _____

Do you notice a large number of children struggling for the same materials or having to wait more than five minutes to use them?

Sometimes _____ Always _____ Never _____

12. Variety: Are there toys and materials for activity times (hoops, balls, wagons, trikes, large climbing blocks)?

Sometimes _____ Always _____ Never _____

Quiet times (puzzles, trucks, dolls) and shaping materials (clay and blocks)?

Sometimes _____ Always _____ Never _____

13. Accessibility and organization of materials:

Are the toys and materials within easy reach of the children?

Sometimes _____ Always _____ Never _____

Are the materials neatly arranged so children can tell where things are located and what is available for them to use?

Sometimes _____ Always _____ Never _____

C. Danger Signs

Any of these signals should alert you to possible serious problems:

1. You are not asked to visit the program or encouraged to ask specific questions about what your child will do during the day. You need to observe in a program several times before you have an accurate notion of what is going on.
2. The children move about the program without any guidance from the adult for thirty (30) minutes or more: they have no apparent involvement with anything or anyone.
3. The staff does not respond to the children. They look past them when talking to them and give the general impression of not caring about or responding to children's presence.
4. The staffs' voices often sound angry or cross.
5. The staff seem overwhelmed with the work and responsibility of caring for children.
6. The staff are physically rough and abuse the children.
7. The centre is dirty and/or unsafe. The staff are messy or sloppy in physical appearance.
8. Your child appears unhappy and suddenly doesn't seem to be eating or sleeping well and doesn't have much enthusiasm for playing with you, other children and his/her toys. Your child may be reluctant or refuse to go to school.

AREAS OF PARTICULAR IMPORTANCE – SPECIAL NEEDS

School Philosophy

The board, staff, parents and volunteers at the preschool believe and identify the following points in their mission statement. This should be available in print form for families.

- children with special needs are children first and that opportunities for learning should be available for all children Yes _____ No ____
- children with special needs, regardless of the severity of disability, have the potential to benefit from developmental activities Yes _____ No ____
- children with special needs benefit from interaction with non-disabled peers Yes _____ No ____
- the family is the main support and advocate for the child and their needs, priorities and choices must be recognized and respected Yes _____ No ____

Accessibility

- The preschool is close to our home
- within walking distance Yes _____ No ____
- within a 10-15 minute drive Yes _____ No ____

If I cannot take my child to preschool, the school facilitates the co-ordination of

- parent car pools Yes _____ No ____
- volunteer drivers Yes _____ No ____
- school bus Yes _____ No ____

The preschool is physically accessible

- few or no steps Yes _____ No ____
- washrooms close to classroom Yes _____ No ____
- suitable classroom/playground equipment and toys Yes _____ No ____
- Hours of operation of preschool are convenient and/or flexible enough for my child to attend Yes _____ No ____
- for me to observe and participate Yes _____ No ____
- for me to attend meetings with teachers and other staff Yes _____ No ____
- for my child's consultant (e.g., physiotherapist) to participate Yes _____ No ____

Parent Involvement

My priorities for my child's educational needs are incorporated into the preschool setting

- staff have regular and formal system to set goals for preschool activities Yes _____ No ____
- I participate in setting these goals Yes _____ No ____
- a structure exists to resolve differences of opinion Yes _____ No ____

I am assisted in providing home activities for my child the school communicates regularly with me regarding my child's development by:

- daily 'lunch bucket' notes Yes _____ No ____
- informal but regular talks with the teacher Yes _____ No ____
- formal weekly or monthly meetings Yes _____ No ____
- written reports on my child Yes _____ No ____
- staff are willing to share teaching strategies with me and to help me plan a home program Yes _____ No ____
- staff are available to visit me in my home to observe and to offer suggestions when necessary for home activities Yes _____ No ____

I have opportunities to acquire information and skills that may benefit my child

- the preschool provides parent education workshops which focus on priorities set by parents Yes _____ No ____
- the preschool encourages parents to attend educational programs sponsored by other agencies Yes _____ No ____

I have a range of opportunities to participate in the preschool program

- to observe my child in the classroom Yes _____ No ____
- to volunteer as an aide in the classroom or in other preschool activities Yes _____ No ____
- to establish, review and monitor preschool policies Yes _____ No ____
- to participate in ongoing evaluation relating to staff and preschool program Yes _____ No ____

Staff Training

- Staff have thorough knowledge of normal growth and development in young children Yes _____ No ____
- Staff have the qualifications and skills to meet my child's special needs and/or are willing to access resources to assist us in developing a program Yes _____ No ____
- Staff encourage the involvement of community resources (e.g., physiotherapy) when appropriate in planning a program for my child, and incorporate specialist input into daily home/school activities Yes _____ No ____
- Staff have opportunities to further their education through in-service workshops or other educational avenues Yes _____ No ____
- Staff recognize the importance of providing a range of options for parent involvement in the preschool program and structure services to facilitate this Yes _____ No ____
- Staff are able to establish and maintain good working relationships with parents Yes _____ No ____

Program Components

- My child's needs are continually evaluated Yes _____ No ____
- Functional assessments are used in such a way that they accurately reflect my child's abilities Yes _____ No ____
- The program emphasizes the development of social, communicative, and cognitive skills Yes _____ No ____
- The program focuses on my child's strengths, and interests and activities which build on these are planned Yes _____ No ____

CLOSING THE CHILD / FAMILY FILE

Families leave the Infant Development Program for a number of reasons. Typically these reasons include the following. The child reaches age 2½ or 3 and moves from the Infant Development Program to preschool or daycare. The family may move to another community. Some children "catch up" to the norm for their age and move out of the program. Other families may not want to continue involvement with the program. When a family leaves the Infant Development Program, the following procedures should be followed:

1. Ensure that the family has a contact person that may be referred to for ongoing information or support regarding their child's development. For many children, this will be a Supported Child Care Consultant. For other children, this could be a Public Health Nurse, a social worker from MCFD, a resource parent from the Family Support Institute or a Family & Children's Services Coordinator through an Association for Community Living. When you and the family have determined who would be the most appropriate contact person, ensure that his/her name, address and telephone number are available in writing for the parent. This information should also be included into the closing report on the child and recorded on the Closing Information Form. Determine with the parent how much information (if any) should be transferred from the IDP to the contact person.

2. Fill in the Closing Information Form, and staple the form into the back of the child's file.

3. Determine with the parent who should receive the Transition Report on the child. A letter should also be written to involved professionals informing them that the youngster is leaving the Infant Development Program. Send Letter to Referral Source. Typically, professionals who should receive this information would be the family physician/paediatrician, the Public Health Nurse, the director of the preschool that the child will be attending, and the Supported Child Care Consultant.

4. Discuss with the parent(s) their interest in providing the IDP with post program follow up information and ask if they would mind being contacted by the program at a later date for program evaluation purposes. Record this in the child's file.

5. It might be useful for some parents at this time to ask if they would be interested in serving on a committee such as the Advisory Committee for the Infant Development Program or as a board member for the sponsoring society. Some parents may also be willing to have their name put forward as a contact parent for new parents of children with similar disabilities.

6. It will be necessary to keep the file on hand until such time as annual caseload statistics are compiled. When this is done, the file should be stored in a secure manner and kept in accordance with agency policy.

VERBATIM COMMENTS FROM THE PROVINCIAL PARENT QUESTIONNAIRE

These comments were selected from 33 questionnaires which asked parents a variety of questions concerning home visits made by Infant Development Program Consultants. Responses concerning both the IDP Consultant's approach and attitude, and the most useful aspects of home visits for parents are listed below. The four major "categories" under which the selected comments appear were not defined in the questionnaire but surfaced in the collation of the material. There is some overlap from one category to the next, but these four broad areas represent the most frequently mentioned aspects of the Infant Development Program.

The Parents' Role in the Development of their Infant:

"The visits left me knowing there was lots of work ahead but that I could do something which made me feel better about myself and my child."

"The most useful part of the program was showing parents how to help the child themselves."

"The program has given the tools and knowledge to allow us to help our child develop."

"The most useful part of the program was being involved and not being left on the sidelines looking in."

"I became involved in the development of my child and that has brought me closer to her."

The Infant Development Program as a Support to Parents:

"These visits relieved many of the fears and tensions that we had about our daughter."

"The home visitor was not there to criticize or in any way threaten our home, way of life, etc., but was there to help. We have found her encouragement most strengthening."

"The staff listened to my feelings and made me feel comfortable with the diagnosis."

The Infant Development Program Consultant Approach and Attitude to the Child and Family:

"The infant staff never tried to make us feel like she was `The Professional' and we the `less educated parents'!!"

"The infant staff showed consideration of the manner in which we raise our children and offered suggestions which enriched the play and routines which we already had established."

"The infant staff really enjoyed my child which gave me confidence that she would get devoted, skilful care."

"I liked their acceptance of my son - other professionals seemed to suggest `too bad' and `abnormal', whereas the infant staff seem to see the human side. "Your son is not just a statistical black mark, but a very special person."

Services Provided by the Program:

"I was put in touch with other parents in the same situation which was very helpful."

"The infant staff was willing to include all family members on her visits. I think this is great. Fathers, mothers, sisters, sometimes have a great impact on the infant's life and reaction and, if they are shown how best to play and interact with him or her, this can be very enjoyable to both sides."

"The infant staff was also an encouragement to push for extra medical backup when our child needed a referral."

"We were encouraged to seek a doctor who would be willing to look further into my little fellow's medical needs."

"A fair amount of background information was gathered about our infant. This is a must as it showed concern and professionalism."

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SECTION VI RESOURCES

INFANT DEVELOPMENT PROGRAM BUDGET

FOR IDP OFFICE WITH ONE FULL TIME IDP SUPERVISOR

(SAMPLE ONLY)

Salary			
	1 IDP Staff		**+/- 45,000**
	1 Clerical person	10 hrs/wk @ $15.00/hr	**7,200**
Benefits		approximately 20% of salaries	
Insurance	professional liability and business use of car		**400**
Telephone	business rental and tax		**> 1,500**
	long distance (depending on area)		**> 1,500**
Office Supplies	to include computer costs, postage, photocopying, letterhead, etc.		**> 3,000**
Program Supplies	toys, books, journal subscriptions, professional dues		**> 3,000**
Courses, Conferences, Inservice (twice a year), UBC Summer Institute on IDP			**> 2,000**
Transportation		will vary, given geography	**> 3,600**
Rent and Overhead		will vary	
Administration		approximately 10% of total budget	
Start up (one time only)	to include: book and toy library, office equipment, initial 1-2 month practicum		**> 10,000**

RECOMMENDED RESOURCES FOR INFANT DEVELOPMENT PROGRAMS

It is estimated that approximately $10,000 is required by an Infant Development Program for resources at the start of a program. This figure includes the costs of office equipment, audio-visual equipment, assessment tests (Gesell) and curriculums, and books.

OFFICE EQUIPMENT

a) One desk - with drawers that can be securely locked
b) Three office chairs
c) Telephone - answering service or machine
d) Filing cabinet - legal size, must be secure
e) Book case - large
f) Shelves for toys
g) Tack boards (small and large)
h) Stationery
- printed letterhead;
- envelopes - legal size and large brown;
- files - 100 minimum;
- cards - index dividers for B.F. system;
- cards for lending library (toys/books)

i) Stamp - (location) Infant Development Program, address, postal code, telephone number
j) Computer or access
k) Program brochures and posters

AUDIO VISUAL EQUIPMENT

Sponsoring Society or other community group may be able to lend these.

a) Kodak carousel slide / digital projector
b) Screen
c) Cassette tape deck
d) Video equipment
e) Slide show on Infant Development Programs in B.C. (available for loan or purchase from Provincial Advisor)

GESELL KIT AND TRAINING PACKAGE

The Gesell Assessment is the standard assessment used in all Infant Development Programs in British Columbia.

The assessment is completed at the request of the parents and can be the basis of the reports to families and other involved community partners. Proficiency in administration of the Gesell, acquired through training and practice, is mandatory for all staff. A package of instructions will be given to new staff outlining the method necessary to acquire the necessary skills.

The Gesell Kit may be ordered from:

Annie Wolverton
Regional Advisor, Lower Mainland
Supervisor, Burnaby-New Westminster IDP
2702 Norland Avenue
Burnaby, BC V5B 3A6
Phone: 604-292-1291
Fax: 604-299-5921

Hull Information Services
Developmental Test Materials
PO Box 3059 Avenue
Schenectady, NY 12303-0059
Telephone: 518-428-5537
Fax: (516) 370-0341

The Training Package is available through the Regional Advisors' and the Provincial Advisor's offices. It includes tapes, printed resources and samples of reports.

RESOURCES PACKAGE

A package containing lists of resources and a list of financial benefits, grants and deductions that families with a child with a disability are entitled to claim, with sample application forms, is available from the Provincial Advisor's office.

BOOK AND VIDEOTAPE LIBRARY

The Provincial Advisor's Office keeps an updated list of recommended books and videos for Infant Development Programs and regularly circulates information on new publications in the following areas. The estimated cost of a start-up library is $5,000.

Advocacy

Assessment/Curriculums

Attachment

Autism

Cerebral Palsy

Child Behaviour and Management

Children at Risk for Abuse and Neglect

Death of a Child - Parental Bereavement

Development in Infancy

Down Syndrome

Early Intervention

FASD and Other Drug-Related Disabilities

First Nations materials

Hearing Impairment

Impact of a Delay for Child and Family

Intellectual Disability

Language Development

Medical Texts

Multicultural materials

Multiple Disabilities

Parent Experiences

Parents with Mental Disabilities

Poverty

Prematurity

Seizure Disorder

Spina Bifida

Visual Impairment

Working with Families

JOURNALS

It is recommended that each Infant Development Program subscribe to, or have access to, the following journals. There are many more specialized journals or newsletters available dealing with specific disabilities. However, we do not recommend subscribing unless you have a child and family in your program with that specific condition. All journals are available through the Provincial Office and or Regional Advisors.

Topics in Early Childhood Special Education:
PRO-ED
P.O. Box 550
Austin, Texas 78789-0603

Journal of Early Intervention:
Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091

Infants and Young Children:
Aspen Publishers, Inc.
P.O. Box 64141
Baltimore, Maryland 21264-4141

Zero to Three:
National Center for Clinical Infant Programs
P.O. Box 96529
Washington, D.C. 20090-6529

Exceptional Parent:
Exceptional Parent
P.O. Box 3000, Dept. EP
Denville, New Jersey 07834

IMP – Infant Mental Health Promotion Project
Dept. of Psychiatry and Community Health Systems Resource Group
The Hospital for Sick Children
555 University Avenue,
Toronto, Ontario M5G 1X8

PLAY RESOURCES AND BOOKS ABOUT TOYS

PLAY RESOURCES

1. Canadian Association of Family Resource Programs

#101 - 30 Rosemount Avenue
Ottawa, Ontario K1Y 1P4
Telephone: (613) 728-3307
Fax: (613) 729-5421

2. Toy Testing Council

The Canadian Toy Testing Council is a non-profit, voluntary organization founded in 1952 by parents concerned about toy quality. Their publication, which is listed below, is updated and published each year.

Canadian Toy Testing Council
P.O. Box 6014, Station J
Ottawa, Ontario K2W 1T1

3. The Toy Report:

Available from bookstores or from the Canadian Toy Testing Council, address above.

WHERE TO PURCHASE TOYS

1. Catalogues

It is recommended that staff request the following companies/distributors to put them on a mailing list so that updated catalogues are regularly received by Infant Development Programs. Specify that you are interested in catalogues relating to educational materials for Early Childhood Special Education.

Communication / Therapy Skill Builders
3803 East Bellevue, P.O. Box 42050
Tucson, Arizona U.S.A. 85733
Toll Free: (800) 866-4446
Fax: (602) 325-0306

Discovery Toys
1054 163A Street
Surrey, B.C.
(604) 535-8697

Louise Kool and Galt Ltd.
1147 Bellamy Rd., Unit 6
Scarborough, Ontario M1H 1H6
(416) 439-4322
Toll Free: (800) 268-4011

Play and Learn Mail Order Service
B1 - 116 - 103rd Street
Saskatoon, Sask. S7N 2Y7
Toll Free: (800) 667-9772

Preston
3220 Wharton Way
Mississauga, Ontario L4X 2C1
Toll Free: (800) 387-3267

2. Toy Stores - Lower Mainland area

Empire Music
8553 Main Street
Vancouver, B.C.
(604) 324-7732

Granville Island Toy Co.
1496 Cartwright Street
Vancouver, B.C.
(604) 684-0076

Great West Wholesale Ltd.
1670 Pandora Street
Vancouver, B.C.
(604) 255-9588
(Requires purchase order)

Kaboodles
4449 West 10th Avenue
Vancouver, B.C.
(604) 224-5311

Moyer's Teacher's Stores
4480 Halifax Street
Burnaby, B.C.
(604) 299-5911

Toy Box
3002 West Broadway
Vancouver, B.C.
(604) 738-4322

Toys 'R' Us
Various locations
(Use purchase order)

Vancouver Kidsbooks
3083 West Broadway
Vancouver, B.C.
(604) 738-5335

Zellers
(Various locations)

3. Equipment

Free to Be - Resources for Independent Living
(physio accessories and adapted equipment)
5315 West Boulevard, Vancouver, B.C.
(604) 267-0831

T.J.'s The Kiddies Store
(Various locations)
(car seat rentals, new and used baby furniture and equipment)

TOY SAFETY

The following notes on safety are to be considered in light of all toys purchased or donated to Infant Development Program toy libraries.

- It should be free of sharp edges or points including corners. An infant is continually falling as she masters getting from one place to another. Any sharp object in the path of her fall can be hazardous.

- It should have no exposed mechanical parts that might catch small fingers.

- Be cautious of toys run by batteries. The batteries may leak acid and cause disfiguring burns when an infant tries to mouth the toy. Supervision is essential.

- It should have no small or removable parts that a baby could put in her mouth. The danger is that baby might inhale them, blocking her windpipe and causing death by suffocation. Be particularly careful about buttons and button eyes on stuffed toys.

- It should be unbreakable. Avoid brittle plastics, which break into sharp splinters. Also avoid rough woods which splinter, and glass objects, including glass hand mirrors.

- It should be safe for chewing and washable. Avoid dolls and stuffed animals if the hair fibres can be pulled off. Avoid painted toys unless they are clearly labelled non-toxic, which means that the paint is free from poisonous lead.

- Avoid balloons. They cause numerous suffocation deaths by becoming entrapped in the throats of infants and young children, even though they were inflated moments earlier.

- Select the right toy for baby's stage of development. For example, a ride-on toy is an excellent choice for secure walker, but a hazard to a newly walking baby who is unable to lift her leg to mount it without falling into the toy.

- Toys that have lasting value over many stages of interest in a baby's and young child's growth are the best purchase. An example would be a cart that could first be used as a walker and later as a baby carriage or wagon for an older tot.

Above taken from: Good Things For Babies, Sandy Jones: Houghton Mifflin Co. 1976.

- Toys should be washed and checked for deterioration on a regular basis.

- Cut off all strings, ribbons and labels from toys

Discovery Toys has a Choke Tube that can be used to check the size of a toy or an item on a toy to ensure it is not a choking hazard

See note under health and safety on toy washing procedures.
For play groups, toy lending library and home visit materials.

CHILD-PROOFING YOUR HOME FOR SAFETY

1. Things to lock up or move to high, out of sight, inaccessible places: insect killers, cleaning materials, shampoos, medicines, alcohol, aspirin, lighter fluid, cigarettes, matches, lighters, plastic bags.

2. Pad sharp corners of furnishings which your child may pull up to or bump into.

3. Keep electrical cords to small appliances out of reach; adjust lamp cords so that the cord is not easily accessible; hide or tape them to the wall. Repair any frayed cords. Keep appliances flush against the wall.

4. Cap all electrical outlets not in use.

5. Add decals or a masking tape X to sliding glass doors, set low at your child's eye level.

6. Keep pot handles turned inwards on the stove; remove stove knobs when not in use.

7. Remove breakable and valuable objects from your child's reaching and climbing range.

8. Place good books on high shelves or jam them in tight. Keep old magazines or children's books on accessible bookshelves.

9. Place and use protective gates at all stairways. They will be useless unless all family members latch them securely, always.

10. Keep off limit rooms latched. Tie a warning bell onto closed doors.

11. Tie cabinet doors securely shut (strings or rubber bands), or use special child-proof locks.

12. Remove poisonous plants; check before purchasing plants to make sure they are safe.

13. Remove or replace slippery throw rugs with non-skid rugs.

14. Caution all family members to keep the toilet lid closed or bathroom door shut; never leave any water in the bathtub.

15. Always test your child's bath water with your forearm; young children cannot tolerate the hot temperatures adults enjoy. Be sure the tub has a non-skid surface. Use a tub mat or stick-on tub strips.

16. Keep your child away from wet slippery floors and freshly shampooed carpets until completely dry.

17. Store or repair unsturdy or splintered furniture.

18. Examine play, sleep and living areas daily for sharp, dangerous, or tiny objects; remove pencils, scissors, Popsicle sticks, pins, forks, nuts, popcorn, small hard objects, etc.

From *HELP...at Home*, 1988, VORT Corporation, Palo Alto, CA 94306

19. Be sure that there is no lead-based paint available on toys, walls, or furnishings.

20. Place objects in centres of tables, not on the edges. Do not use table cloths that could be pulled off.

21. Constantly supervise outdoor play, even with a securely fenced yard.

22. Do not let your child play with toys which have strings 12 inches or longer; remove mobiles and crib gyms with strings as he becomes active and can reach; it is easy for young children to become strangled in strings.

23. Be sure that your child cannot stick his head through crib or playpen slats, balcony or porch railings. Slats should be less than 2-3/8 inches apart. Make sure there is a snug-fitting mattress. The mattress should be no more than two fingers from crib or playpen sides.

24. The sale of baby walkers has been banned in Canada.

25. Post your local poison control number next to your phone.

26. Check for nails or screws protruding under tables or chairs; watch for frayed carpet which can expose carpet tacks.

27. Playpen mesh should be small weave, smaller than baby buttons. This will prevent your child's buttons getting caught which could potentially choke him if the buttons are near his neck.

28. Be careful if you microwave your child's bottle to warm up formula or milk. This method can heat liquid unevenly and there could be hidden pockets of scalding milk. Be sure to shake the bottle or stir the liquid, and test before using.

29. To avoid crib falls, set the crib mattress at its lowest point before your baby can pull up to stand.

30. Environmental choking hazards for babies to keep out of reach include: un-inflated balloons or balloon pieces, baby aspirin tablets (mash them up or use liquid), pop tops of beverage cans, egg shells, coins, peanuts, small watch batteries, safety pins.

31. Toys and toy parts must be bigger than 1.25 inches in diameter and longer than 2.5 inches to prevent choking. Infant toys manufactured are supposed to meet these government regulations. (If you have older children at home, those toys may not meet these standards and thus can pose a risk if your child plays with them.)

NOTE: Child protection kits are available commercially through many toy and baby shops. They are inexpensive and contain latches and locks for cabinet doors and drawers, electrical outlet covers, corner cushions and doorknob covers that children cannot turn.

TOY SELECTION FOR INFANT DEVELOPMENT PROGRAMS

See toy washing procedures under health and safety.
Starting from birth, we have clustered typical abilities/ interests of infants according to age ranges. This guide can be used by staff to assist in developing an Infant Development Toy Library or by parents in choosing appropriate toys for their child.

Age Approximately 0 - 3 Months
During this period, babies move from: enjoying listening to soft sounds and staring at faces, movement and light to: focusing on their fingers and exploratory play with their hands. A parent's face is baby's best 'toy' during this period.

- Mirror or mirror toys (unbreakable)
- Small soft squeaky animals and rubber tactile toys
- Play gyms
- Activity blanket
- High contrast pictures
- Musical mobile with the animals or faces in direct line of vision for baby in the crib
- Light weight, easy to hold rattles, wrist and foot rattles
- Soothing musical toys

Age Approximately 4 - 8 Months
Babies learn to reach and grasp with one or both hands. Toys are mouthed, banged, shaken, and eventually transferred from one hand to another. Therefore, an object that is colourful, light and safe for baby is a good toy.

- Squeaky toys
- Activity box and boards
- Cloth colourful balls
- Cloth and board books, bath books
- Peek-a-boo Roll
- Attaching Bell Blocks
- Rolling Bells - Kombi

Age Approximately 8 - 12 Months
Babies may now reach and grasp accurately and with control. They may deliberately let things go and search for a toy that has been dropped or rolls out of sight. Almost everything that can be picked up (e.g. lint) may be put in the mouth so be careful with toys that have small parts (e.g. older brother's or sister's toys). Babies this age love to repeat activities over and over and over again.

- Various size board and cloth books that have clear pictures
- Shape sorter - balls in a clear bowl
- First Blocks Form Box
- Clear balls with things inside
- Containers, such as plastic bowls, wide at top for taking out and putting in
- Fisher Price, "Baby's First Blocks"
- Baby Duplo
- Fisher Price Floating Family

Age Approximately 12 - 18 Months

Babies may now be able to use their thumb and index finger together to pick up small objects e.g. (raisins) and to manipulate buttons and knobs. They may turn things with their index finger (e.g. dial on toy telephone) and open and close containers. Toys that encourage fine motor exploratory play will be useful. Babies who are mobile enjoy push and pull toys and may carry a doll or teddy around. Books are becoming increasingly interesting and babies may point to familiar objects (e.g. animals, household objects, toys).

- Toy telephone
- Large cars and trucks (no sharp edges)
- Surprise toys (Jack in the Box)
- Balls of varying sizes
- Board books with simplified, realistic pictures
- Nesting/stacking cups
- Dolls and teddies
- Wind up musical toys
- Basic block building set
- Peg boards, Discovery Toys Stacking Pegs
- Push toys
- Pull toys
- Fisher Price Activity Table

Age Approximately 18 - 24 Months

Toddlers have a longer attention span (e.g. three minutes) and will be more likely to sit and play with a toy and have a definite goal in mind associated with the toy (e.g. fitting three pieces of a puzzle together). They have no concept of sharing but will play beside other children. They may be persuaded to trade toys but are usually too possessive to share. They may now turn pages singly and enjoy having access to their own books. They may throw and kick balls, enjoy 'ridem' toys, pulling wagons and pushing buggies.

- Simple puzzles
- Stacking blocks
- Nesting toys
- Simple large Lego - Duplo
- Books, e.g., "Babies"
- Surprise Toys (Jack in the Box)
- Pegboards
- Spools and shoelaces for threading
- Hammer and balls
- Fisher Price Musical Instrument Set
- Posting toys

Age Approximately 24 - 36 Months

The child's play is now more purposeful and tasks are more likely to be finished. As well, the child is becoming more imaginative and creative in her play. She may imitate common household tasks such as cooking or helping mommy or daddy about the house. Paper and paste, crayons and pencils or play dough can be used appropriately and are enjoyed because of their creative potential. Songs, rhymes, books and records are favourite activities.

- Interlocking puzzles,
- Storybooks with simple stories and rhymes, more detail in pictures
- Stacking boxes
- LEGO or building materials
- Hand puppets, crocheted hand puppets
- Peg board, wooden with large pegs and holes
- Shape sorters
- Chalkboard and chalk, large non-toxic crayons
- Tea sets, cooking utensils

SECTION VII COMMUNITY EDUCATION

INFANT DEVELOPMENT PROGRAMS FACT SHEET

PREVENTION AND EARLY INTERVENTION FOR CHILDREN

WHAT ARE WE?

Within the continuum of services and supports for young Canadian children and their families, there are specialized programs that focus on infants and children who have a developmental delay or who are at risk for delayed development for established, biological and/or psychosocial reasons.

Infant Development Programs in British Columbia provide a range of family-centred prevention and early intervention services and supports for such families and infants. The first Infant Development Program in British Columbia was established in 1972 and there are now 51 programs in the province funded by the Ministry for Children and Family Development. At the provincial level, there is a Provincial Steering Committee, a Provincial Advisor and Regional Advisors available to support staff and communities in delivering high quality services. Primarily, the programs serve children from birth to three years of age, while a few serve children up to the age of five. Programs are administered by a variety of community agencies. They have evolved to meet the needs of each community and to complement the mix of services available.

WHO ARE THE CHILDREN AND FAMILIES WE SERVE?

Infant Development Programs are designed to serve infants who are at risk for developmental delay and also their families. Infants can fall within one or more of the following risk factor categories:

- Established risk - Infants who have diagnosed medical disorders. An established range of developmental disabilities may be associated with these disorders, which include genetic and chromosomal syndromes; neurological disorders; congenital malformations of the nervous system; sequellae of infections of the nervous system; metabolic disorders and others
- Biological risk - Infants who have a history of prenatal, perinatal, neonatal and/or early developmental events that may have affected the central nervous system and may result in developmental difficulties for the child. Biological complications may include: birth asphyxia or trauma; prematurity; physically disabling conditions; increased genetic risk for disability; apparent global developmental delays
- Psychosocial risk Infants who have a statistically increased probability of delayed development because of individual susceptibilities that are aggravated by environments in which there may be inadequate response to the infant's physical, developmental and/or social-emotional needs. Parental inexperience/developmental delays or mental health problems, attachment difficulties, non-organic failure to thrive and child neglect or abuse are included in this category

Programs do not require that a child have a diagnosis for families to access our services. Referrals are made by parents, physicians, public health nurses and other community professionals in a position to assess developmental concerns in young children.

WHAT DO WE DO?

We provide an integrated approach to infant development and family-centred intervention that is parent-led and responsive to parent strengths, competencies and priorities.

The family is the major decision-maker in a child's life, and the active involvement of the family throughout our involvement is essential to a satisfactory and meaningful outcome.

Through a transdisciplinary approach and in collaboration with other Service Providers, we aim to provide the highest level of opportunity for the optimal development of the child and family unit. Support is provided within the child's natural environment where the infant development consultant serves many functions.

Services provided are tailored to child and family need and may include:

- Home visits
- Informal and formal child assessment and family needs assessment, using a variety of tools
- Support to enhance parenting skills and increased understanding of child development
- Sharing information on typical and atypical child growth and development
- Intervention to promote positive parent-infant interactions and support for the relationship
- Planning interventions to promote secure infant attachment
- Early intervention in all developmental domains (gross and fine motor, social and emotional, language and cognitive)
- Assistance to families in connecting with other families for parent to parent support
- Assistance to families in accessing more specialized services and information about additional community resources and supports
- Assistance to parents in obtaining information about their child's condition or diagnosis
- Support to the family when a diagnosis of developmental delay or medical condition exists
- Acting as service coordinator or supporting a family member or other professional in this role
- Advocacy for and with families in their relationships with health, social and community services
- Provision of parent-child group programs or support to families in accessing community programs
- Community-wide planning with other service providers to prevent duplication or fragmentation of service and to identify gaps in service
- Public education to promote the benefits of early identification, intervention for children and families at risk

Within a family-centred philosophy, the infant development consultant supports families in the identification of their needs, resources and service requirements. The family's involvement and participation is a recognized key factor in the achievement of successful outcomes. Collaboration across individual professionals and agencies is also key to ensure that family life is strengthened rather than stressed by intervention.

We serve over 6,000 children each year throughout the province of BC, primarily through home visits on a monthly or bi-weekly basis. Frequency of service is established according to family and child needs, and is crucially dependent on the resources available to each program and other community supports available to the family.

STAFF TRAINING AND EXPERTISE

Our Infant Development Consultants are skilled in providing an effective home-based intervention service. They benefit from continuous staff development opportunities locally, regionally and provincially. A Certificate and Diploma Program in Infant Development are offered through the University of British Columbia (UBC). IDP Consultants have training in one or more of the following disciplines: child development; psychology; social work; physiotherapy; occupational therapy; child and youth care; nursing, education; early childhood education; developmental services or other related disciplines.

Infant Development Consultants bring a unique set of skills and abilities to work with high-risk infants and their families who are at risk as a result of poverty, parental unemployment, parental mental health issues or other conditions that may make it more difficult for parents to meet the child's developmental need. Their expertise covers knowledge of typical and atypical child development; observational skills; the ability to assess child and family strengths and needs; appreciation of issues related to family dynamics and child-rearing; training with respect to supporting those who experience grief and loss; and advocacy skills.

A family-centred service is promoted to encourage positive parent-child interactions and to promote the infant's optimal developmental progress. The relationship of secure attachment to developmental accomplishment is promoted by the active encouragement of parents to recognize their infant's cues and to respond in ways that foster a sense of security and play.

WHAT ARE THE OUTCOMES OF EARLY INTERVENTION?

What happens to children in the first years of life will play a large role in the path they will follow as adults. Recent research in the neurosciences provided powerful evidence for the influence of the early years on the children's base for competence and coping skills. These influences may affect learning, behaviour and health throughout their whole life.

Infant Development Programs are effective in promoting positive outcomes for the children and families who are nurtured through the children's early years.

TO CONTACT THE IDP IN YOUR COMMUNITY, CALL YOUR PUBLIC HEALTH NURSE.

This fact sheet is based on work done by the Ontario Association for Infant Development

Family Centred Care

The Kennedy Institute on the Family defines family centred care as a "collaborative relationship between families and professionals in the continual pursuit of being responsive to the priorities and choices of families".

Infants and Young Children 92, (4) (3)

"Family centred refers to a particular approach to intervention that aims to support and strengthen parents' abilities to nurture and enhance child well being and development."

Carl Dunst, UBC, 1997

BC IDP 2003

Program Characteristics Associated with Positive Child/Family Outcomes

- Family Centred Practice
- Open Door – Families may access service
- Long Term, Meaningful Relationship with Staff
- Comprehensive Approach
- Builds on Child and Family Strengths
- Flexible – Amount and Intensity of Contact Individually Determined
- Well Trained Staff – Connected and Supported
- Inter-Agency Collaboration

BC IDP 2003

Family Centred Care

Family-centred care results…in practices in which the pivotal role of the family is recognized and respected. Families are supported in their caregiving roles by building on their unique strengths as individuals and families. Opportunities are created for families to make informed choices for their children, and more importantly, these choices are respected.

Shelton & Stepanek, J. (1994)

Family-Centred Care for Children Needing Specialized Health and Developmental Services (2nd Ed.), Association for the Care of Children's Health, Bethesda, Maryland, p.4

BC IDP 2003

Research Base for Family Centred Care

Parent Education Programs

- Improved child language
- Improved parental sensitivity to child
- Better learning environments at home
- Sustained gains in cognitive development

Programs that Offer Family Support

- Positive effects on child more lasting
- Parents have more positive approach to life
- Parents place higher value on education
- Improved parent-child relationship

Child Development Research

- Transactional model
- Ecological model

Family Support Movement

- Child cannot be viewed as separate to family
- Family cannot be viewed as distinct from community in which it lives
- Children and their families cannot be considered apart from the policies and institutions of the larger society

Adapted from:
Family Centred Child Care,
Ellen Galinsky, Bernice Weissboard

BC IDP 2003

Core Practices of Family Centred Approaches to Intervention

- Families are treated with dignity
- Practitioners are sensitive to family diversity
- Family choice and decision making occurs at all levels
- Information is shared in a complete and unbiased manner
- Focus of intervention is determined by family
- Supports offered are provided in a flexible manner
- Broad range of supports are used
- Strengths of families are used as resources
- Relationships are characterized as partnerships
- Help giving styles are empowering

C. Dunst (1995),
C. Dunst and C. Trivette (1996),
C. Dunst et al (1988, 1990, 1994)

BC IDP 2003

Tools Used By IDPs To Identify Family Needs

Parents Checklist for Home Visit

- 1 page that covers parents' needs for information regarding that child

My Child and Family

- 3 page survey to document child's likes and interests and family routines

Family Needs Survey

- 4 page survey to document family needs for information, support, community services and financial needs

Parent Assessment of Needs

- 9 page survey to document more detailed information about the child and family interests, activities and priorities for goals for child/family

BC IDP 2003

Family Centred Practices for Team Meetings

- Team meetings belong to families and professionals together.
- Families are invited to speak first.
- Medical terms are always explained in everyday language.
- Staff tell families when they are not sure or do not have an answer.
- Professionals are open with families about differences of opinion.
- Professionals speak of a family in the same manner whether or not the family is present.

BC IDP 2003

Family Centred Child Care

Traditional Parent Involvement	Family Centred
Child seen as independent unit	Child seen as part of Family
Families seen as independent units	Families in context of community
Parents seen in child rearing role	Parents have many roles
Parent behaviour function of knowledge and attitude	Parent behaviour result of broader influences
Teacher is expert	Teachers and parents have knowledge and skills to share
Teacher focuses on child to compensate for deficits in the family	Teacher builds relationships with parents to foster child growth

BC IDP 2003