Early Intervention Colorado
for Infants, Toddlers & Families

An Academy for Developmental Intervention Assistants

ORIENTATION TO EARLY INTERVENTION

Instructor's Guide & Handouts

Module A: History, Legal Precedents, and Values of Early Intervention Services
Module B: Child Development
Module C: Overview of Exceptionalities

The PAR²A Center

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ORIENTATION TO EARLY INTERVENTION

Instructor's Guide

This manual is accompanied by a PowerPoint document titled, "Orientation to Early Intervention Slides"** that the instructor may project or print slides and convert them into transparencies to project them using a traditional overhead projector.*

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TECHNICAL SUPPORT FOR CO-TOP*EIS ACADEMIES

The following technology information is to assist with using the video clips within the slides of the CO-TOP*EIS Instructors' Guides.

You must have Media Player for viewing (Windows & Mac versions available). We also recommend using external speakers for your computer.

To view a video, you must have Media Play installed on your computer. Media Play operates on Windows and Mac systems and is available FREE. To obtain Media Player visit:

http://www.microsoft.com/windows/windowsmedia/player/10/default.aspx

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ACADEMY INTRODUCTION

This academy is designed to provide an introduction to the early intervention services for the Developmental Intervention Assistant (DI Assistant). This academy will provide the DI Assistant with an overview of the field of early intervention services under Early Intervention Colorado and Part C of the Individuals with Disabilities Education Act (IDEA).

The content consists of introductory material regarding history, legal precedents, and values of early intervention services as well as overview of cild development and exceptionalities
The learning from this Academy will provide the foundation for the DI Assistant's learning with all other Academies.

While many of the activities in the academy assume that the participants are in DI Assistant positions, your audience may consist of in-service DI Assistants as well as those who are not in DI Assistant positions yet. You may advise the latter group to reflect on their previous work experience or any related experience with infants, toddlers, and families with children with special needs.

This manual is accompanied by a PowerPoint document titled, "Orientation to Early Intervention Slides" that the instructor may project, print slides from or convert into transparencies to project using a traditional overhead projector.

Note to Instructor:
At the beginning of the training, advise participants to procure a 3-ring binder to keep handouts, personal notes and materials used in the class. It is recommended that the instructor brings a 3-hole punch to class for participants' use or make sure that all handouts are run on 3-hole paper. Instructor may choose to copy different handouts in different colored papers for easy identification and remembering.

A. Discussion: Logistics & Norms (Slide 3)

At the beginning of the training:

a. Welcome participants and introduce yourself as the instructor(s).
b. Give them a brief overview of who you are, where you are from, and information about your background that is relevant to teaching this academy.
c. Have participants at each table introduce themselves (who they are, where they work, and what they do)
d. Explain the concept of establishing group norms with regards to what behavior is considered acceptable and is important to the class (e.g. respects others, increases productivity, reduces annoying disruptions) and encourage participants to contribute any norms they consider important (e.g. no side conversations, stick to the schedule etc.).
e. Use chart paper to post the norms of the group.
f. Address logistical issues (e.g., breaks, bathrooms, lunch plans).
g. Encourage participants to ask questions throughout or to post them in a specially marked place (post parking lot chart on wall).

Use the following activity to allow participants to learn not only each others' names, but also something about each other. The activity also demonstrates that each one of us is similar in some ways and different in others.

Note: Do not spend more than 10- 15 minutes on this activity

B. Large Group Activity – Who am I? – Getting to know each other

B.1 Steps:

- Show **Activity: Let us get to know each other** slide (**Slide 4).**
- Give a note card (and a pen/ pencil if they don't have one) to each of the participants.
- Ask the participants to share facts about themselves by creating a *Who Am I?* riddle. Ask them to write four statements about themselves. The last line is a question: "Who Am I?"
- Give participants about 3 minutes to write this.
- Collect the note cards and read them one by one. Each time the participants have to guess who the person is. Have fun with the activity!
- Point out that the picture in **Slide 4** represents the fact that though each picture is a two- dimensional shape; they are all different – in size, colors, and the specific shapes. Similarly, each one of us is similar in some ways and different in others. This understanding is critical when learning about teamwork in early intervention which will be covered in the Academy III: Early Intervention Teamwork Academy.

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C. Orientation to Early Intervention Academy Module Goals

Tell the participants that there are 3 modules in this academy.
Using **Orientation to Early Intervention: Module Goals** handouts and slides **(H1, page 64/ Slides 5-8)**, briefly review the modules with the DI Assistants at the beginning of the class. Remind them that this is an overview only. The goals will be addressed again before each module.

Module A: History, Legal Precedents, and Values of Early Intervention Services (5 hrs)
The DI Assistant will:
1. Demonstrate understanding of the history of the IDEA.
2. Discuss the purpose, required components and rules and regulations for Part C.
3. Describe the organizational structure that enables the implementation of Part C of IDEA in Colorado.
4. Discuss the core values and concepts that guide early intervention services under Part C of IDEA.

Module B: Overview of Child Development (5.5 hrs)
The DI Assistant will:
1. Identify major motor, communication, cognitive, social/emotional, and adaptive milestones.
2. Recognize the risk factors that may prohibit or impede typical development and the protective/resiliency factors that may counteract these risk factors.
3. Discuss the importance of the relationship between child development and the concepts of developmental delays and disability.

Module C: Overview of Exceptionalities (4.5 hrs)
The DI Assistant will:
1. Demonstrate an understanding of state and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA and the Early Intervention system.
2. Recognize the motor, communication, cognitive, social/emotional, and adaptive needs that infants/toddlers have as a result of a developmental delay.
3. Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.

D. Large Group/ Individual Activity: Alphabet Soup/ Glossary

- **Before you continue to Module A,** paste a blank poster on the wall which says: ALPHABET SOUP/ GLOSSARY. Place markers with it.

- Explain to the participants that as we move along in this academy, they will encounter a number of acronyms commonly used in the field of early intervention and special education. Any participant is welcome to come up to the poster board during the breaks and write the acronym they encounter and the full word on the poster. Let it develop into a community of learning!

- Share **Alphabet Soup /Glossary** handout and slide (**H2, page 65/Slide 9).**
- Ask participants to keep this sheet in front of them. As they come across a new word/ acronym, they should jot it down on their handout.
- Have more handouts available so that participants can use them if they complete their first handout.

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Module A: History, Legal Precedents, and Values of Early Intervention Services

A. Module Goals

Use **Slide 10** and **Module Goals** handout (**H1, page 64**) to **revisit** the goals of Module A.

The DI Assistant will:

1. Demonstrate understanding of the history of the IDEA.
2. Discuss the purpose, required components and rules and regulations for Part C.
3. Describe the organizational structure that enables the implementation of Part C of IDEA in Colorado.
4. Discuss the core values and concepts that guide early intervention services under Part C of IDEA.

B. Discussion: What is Early Intervention?

- Ask the participants what early intervention means to them.
- Share the **"What is Early Intervention?"** handout **(H3, page 66)**. Give the participants a couple of minutes to skim through the handout.
- Highlight that the services are provided to children birth through 2 *and* their families
- Ask the participants if they have provided early intervention services. Ask those participants who have already worked in DI Assistants positions to list the services they provide.
- Remind the participants that they will learn more about who is eligible for the services, how these services are provided, who provides these services and their role in early intervention in the remaining part of the Academy.
- Tell the participants that you will now discuss Goal 1.
- Have participants complete a short quiz to get an idea about their current knowledge base.

C. Individual Activity: Pre/ Post Quiz: Module A

This activity will help the DI Assistant assess their knowledge of content covered in Module A. Consider this a "pretest". You will come back to this quiz after completing Module A.

C.1 Steps

- Show **Slide 11** and **Pre/ Post Quiz: Module A** handout **(H4, page 67).**
- Ask the participants to take 10 minutes and complete the test in Handout. Inform them that the answers will not be discussed yet.
- The completed test remains with the participants.
- The questions on the quiz are as below.

Q1. What does IDEA stand for?

- *Individuals with Disabilities Environment Act*
- *Individuals with Disabilities Equality Association*
- *Individuals with Disabilities Education Act*
- *Illicit Drugs Enforcement Agency*

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Q2. When did the last authorization of IDEA take place?

- *1950*
- *1975*
- *2000*
- *2004*

Q3. Which part of the IDEA covers Early Intervention services for infants and toddlers and their families?

- *Part A*
- *Part B*
- *Part C*
- *Part D*

Q4. The federal government requires that the governor must designate a lead agency to receive the grant and administer the program to provide early intervention services for infants and toddlers with disabilities and their families. Which state agency has been designated "lead agency" in the state of Colorado?

- *Colorado Department of Education*
- *Colorado Department of Human Services/ Division for Developmental Disabilities*
- *Colorado Department of Public Safety*
- *Colorado Department of Law*

Q5. What is the purpose of the Colorado Interagency Coordinating Council (CICC)?

- *To provide funds to the state to support the services for infants and toddlers*
- *To train professionals*
- *To provide services to families of infants and toddlers with disabilities*
- *To advise the lead agency for early intervention services in Colorado on how to implement the services.*

Goal 1: Demonstrate understanding of the history of the IDEA

1.1 Lecture: History of IDEA

Mention early intervention services did not develop in a vacuum, but developed as part of an evolution of legislation for persons with disabilities.

- Use **History of Public Policy 1954-2004** slide **(Slide 12)** briefly and tell the participants that as they can see from this overhead, there are many milestones along the way to a mandate for early intervention services. Let them know that you are going to go over all these in detail in the slides that follow.
- Point out that there are two themes represented in this wave of legislation: one is **civil rights** and the other is **educational opportunity.**
- Show **History of Public Policy 1954-1973** slide **(Slide 13)**. Tell the group that we will start by reviewing the first half of the timeline (Note to instructor: do not dwell on this slide, because you will be covering this material in detail on the following slides)

- Show **Legal Milestone** slide (**Slide 14):**
  - In 1954, Brown vs. the Board of Education was a federal case from Topeka, Kansas, that decided education was a basic right subject to equal protection under the fourteenth amendment of the U.S. Constitution, which requires states to provide equal protection under the law to all people within their jurisdictions. Though the case dealt specifically with educational segregation by race, in many ways it marked the beginning of the civil rights movement, establishing the precedent that separate is not equal.
  - In 1964, the Civil Rights Act prohibited discrimination on the basis of race in a variety of public and private enterprises. It implemented the ideas of "equal opportunity" and "separate is not equal." Again, the relationship to students with disabilities or individuals with disabilities can be drawn.
  - In 1965, the Elementary and Secondary Education Act (ESEA) was passed, providing funds to states for services to children with disabilities. This funding was specifically targeted to children in state institutions.
  - In 1972, we saw the PARC (Pennsylvania Association of Retarded Citizens) Decision. In this case, PARC presented a class action suit against Pennsylvania on behalf of children with mental retardation who were excluded from public education. Important principles from this case are (free appropriate public education [FAPE], least restrictive environment [LRE], and parental participation). This legislation laid the groundwork for Federal Public Law 94-142. Also in 1972, was the Mills Decision, a class action suit on behalf of seven students with a variety of disabilities who were being denied a public education? Principles established in this case were "zero reject," "right to due process," and the right to a "free, suitable public education."
  - Also in 1972, was the Mills Decision, a class action suit on behalf of seven students with a variety of disabilities who were being denied a public education? Principles established in this case were "zero reject," "right to due process," and the right to a "free, suitable public education."
  - Also in 1972, the Head State Economic Opportunities Act of 1972 established Head Start programs for economically disadvantaged children.
  - In 1973, Section 504 of the Rehabilitation Act of 1973 was passed. It is a basic civil rights provision which prohibits discrimination against America's citizens with disabilities.

- Show **History of Public Policy: 1975- 2004** slide **(Slide 15).** Tell the group that we will now review the second half of the timeline. (Note to instructor: do not dwell on this slide, because you will be covering this material in detail on the following slides)

- Show **Legal Milestone** slides (**Slides 16-17**)**:**
  - In 1975, Public Law 94-142, the Education for All Handicapped Children Act (ESEA/EHA), was passed, requiring appropriate public education in the least restrictive environment for all school-age children. It allowed services for children beginning at birth, but did not mandate such services.
  - In 1986, Congress passed Public Law 99-457, which extended the provision of multidisciplinary services to children with developmental delay from birth through age 5 (Parts H (now Part B) of P.L. 99-457).

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- In 1990, the Americans with Disabilities Act was passed. The ADA is civil rights legislation designed to protect people with mental or physical disabilities from discrimination based upon disability.
- In 1991, Congress reauthorized services to all children with developmental delay, amending and combining P.L. 94-142 and P.L. 99-457 into one law, P.L. 102-119, and naming the bill "Individuals with Disabilities Education Act"; IDEA. This law gave further direction and refinement for early intervention services.
- In 1997, Congress reauthorized IDEA, now P.L. 105-17.
- In 2004 Congress reauthorized IDEA, now IDEA Improvement Act, P.L. 108-446

- Show **IDEA 2004** slide (**Slide18**) and remind the group that IDEA stands for the Individuals with Disabilities Education Act. IDEA was reauthorized in December 2004 and the name changed to Individuals with Disabilities Education Improvement Act, however, the acronym has not changed.

- The most current version of IDEA is the law that was reauthorized twice, first in 1997 and then in 2004.
  - There are two parts to the law: *Statute* and *regulations*. The statute, which is what this refers to, is the meat of law and the regulations further define and clarify the law. The regulations are based on feedback gathered through public comment. These comments are considered when developing the regulations. The regulations for the Part C portion of the 2004 reauthorization are not yet out.
  - Website: ed.gov – lists all questions asked and comments made
  - Note that IDEA is not an income eligible program. It is a set of entitlements for all children based on disability and their families.
  - Show **IDEA 2004: P.L.108-446** slide **(Slide 19)** and explain that each time a bill is reauthorized the numbers change:
  - "P.L." is an abbreviation for Public Law and is a prefix that is put on every bill that becomes law.
  - The "108" refers to the 108th Congress in which the bill was passed.
  - "446" means that it was the 446th bill passed by Congress

- Show **General Intent of IDEA** slide (**Slide 20**) and explain:
  To ensure that children with disabilities have equal access to public education and are prepared for employment and independent living.

1.2 Large Group Activity: What Does This Mean?

This activity will help DI Assistants to develop understanding of the fundamental values on which IDEA is based.

1.2.1 Steps:

Show **What Does This Mean**? slide (**Slide 21**):

Disability is a natural part of the human experience and in no way diminishes the right of individuals to participate in or contribute to society. Improving educational results for children with disabilities is an essential element of our national policy of ensuring equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities.

- Ask the participants to read this quotation silently and then take a minute to think about what these words mean to them.
- Lead a brief discussion by having people volunteer to share their thoughts.
- Summarize: As illustrated by this quotation from IDEA, this law is built on a very strong value base of the rights of people with disabilities to participate in all of society.

1.3 Large Group Activity: History of Public Policy Timeline

Through this activity the DI Assistant will be able to assess what they have learned with regards to the history of public policy timeline.

Note to the instructor: This activity requires some preparation on your part before the class. Read steps below and prepare poster board and note cards prior to the class.

1.3.1 Steps:

- Show **Activity: History of Public Policy Timeline** slide **(Slide 22)** slide.
- On a poster board create the timeline similar to that on **Activity: History of Public Policy Timeline** slide **(Slide 22).** Do not write what happened in those time periods underneath the timeline.
- On separate note cards, write in large print the different happenings listed on **Slide 12** (e.g. ECSA, PARC decision, etc.). Fold the 11 note cards and put them in a basket/container.
- Post the poster board on the wall.
- Ask one participant to pick out a card from the basket.
- Ask that participant (or you could choose to allow any of the other participants) to say where in the timeline this event happened. Remind participants what that event means. Once the discussion on that event is complete, pin the note card on the timeline on the poster board.

- Continue with other note cards similarly until all note cards have been pinned on the timeline.

- Summarize this activity by discussing why changes were made in the laws/policies. Discuss what the changes mean to how we view disability. Why is participation such an important concept for infants and toddlers with disabilities?

- At the end of the activity, distribute **History of Public Policy** handout (**H5, page 68**) for future reference.

Goal 2: Discuss the purpose, required components, and rules and regulations for Part C

2.1 Lecture: Different Parts of IDEA

- Show **Now let us learn about** slide (**Slide 23**) and let the participants know that next they will be learning about different parts of IDEA followed by the purpose, components and rules and regulations for Part C.

- Use **Different Parts of Individuals with Disabilities Education Act (IDEA)** handout and slide (**H6, page 69/Slide 24**) and introduce the four parts of IDEA.

- Show **IDEA Part A: General Provisions** slide **(Slide 25)** and IDEA Part A:
  - Gives general information about the law, why the law was enacted and who it serves.
  - Gives definitions for terms referenced in the law.
  - Defines what the state and federal government needs to do administratively

- Show **IDEA Part B: Assistance for Education for all Children with Disabilities** slide **(Slide 26)** and emphasize that even though DI Assistants are a part of the early intervention program under Part C of IDEA, they still need to understand the provisions of Part B. In the **Transition to Age 3** Academy, when we discuss transition, we will talk in greater detail about Part B.
  - Part B is the section of the law that requires states to conduct child find activities for children birth to 21 years.
  - Part B serves students through the semester in which they turn 21 or when they graduate with a regular diploma.
  - Highlight that their work falls under Part C

- Show **IDEA Part D: National Activities to Improve Education of Children with Disabilities** slide **(Slide 27)**
  IDEA Part D authorizes discretionary funding for a variety of activities:
  - Research and Innovation
  - Personnel Preparation
  - Technical assistance
  - Dissemination of information
  - Provide an example of Part D funded program in Colorado such as: PEAK Parent Center

- Show **Part C** slide **(Slide 28)** inform participants that you will be covering this in greater depth. Emphasize that the Congressional intent of Part C is to coordinate the use of existing resources, not to create a new program.

- Show **Part C of IDEA** slides **(Slide 29-30)** and explain that Part C provides financial assistance for states to:
  1. Maintain and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families.
  2. Facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources.
  3. Enhance their capacity to provide quality early intervention services and expand and improve existing early intervention services.
  4. Enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations.
     - Discuss the first three points on the slide in your own words, illustrating them with an example or story. For example, Part C provides funds for Early Intervention Colorado to maintain an implement a statewide comprehensive coordinated, multidisciplinary interagency system in Colorado.

- Emphasize Point #4 as follows:
  - A primary theme of Part C and IDEA is access, particularly for populations of children who historically have not had easy or ready access to the services that they need. One of the under-represented populations is the families experiencing homelessness, which is a big focus throughout the state. The definition of homeless is broader than what is commonly thought of.
  - Explain that there is a federal act known as the McKinney-Vento Homeless Assistance Act which each state adheres to. This act includes a definition of who is considered homeless. The term "homeless children and youth" – means individuals who lack a fixed, regular, and adequate nighttime residence …; and includes
    - ✓ children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

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- ✓ children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings
- ✓ children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
- ✓ migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses

- This purpose statement is reflected in the law through the concept of equitable distribution of resources.
- In general, the intent of Part C was not to create a new program, but to provide the "glue" with which to pull existing early intervention programs and services together.

2.2 Small Group Activity: Purpose of Early Intervention

This activity helps the DI assistants to emphasize and connect their learning from the Introduction (where they discussed "What is Early Intervention?") with that of Goal 2.

2.2.1 Steps:

- Use **Purpose of Early Intervention** slide (**Slide 31**) and reinforce that what they will learn through this activity will be important later on.

- Review the material on this slide.
  The purpose of early intervention is:
  - to enhance the development of infants and toddlers with disabilities.
  - to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities.

- Emphasize the following points:
  - the purpose is to support families' capacities and not to usurp their roles .
  - the word enhance presumes the existence of capacity, and that you're building on what exists and not just "fixing a problem".

- Ask the participants to discuss the following two questions on the slide with others at their tables for about 5 minutes:
  - What do each of these purposes mean for you?
  - What do each of these purposes look like in your community?

- As a large group, ask for volunteers to share what was discussed at their tables.

2.3 Large Group Activity: Recap

The purpose of this activity is to review what the DI Assistants have learned in the previous slides (**Slides 23- 31**) and provide them with an opportunity to ask clarifying questions.

2.3.1 Steps:

- Show **Let us Recap** slide (**Slide 32**) and ask the participants these quick questions to review this section.
  1. How many parts are there in the IDEA?
  2. Can you name them?
  3. What is the function of Part A?
  4. What is the function of Part B?
  5. What is the function of Part C?
  6. What is the function of Part D?
  7. What part relates to services for infants and toddlers with disabilities and their families?
  8. Why is it important for professionals working in early intervention to know about Part B?

2.4 Lecture: Required Components of Part C

- Explain that each state must assure in their annual application for funding from the federal government how they are addressing required components (statutory obligations) in order to receive federal funds for Part C.

- Use **Required Components of Part C of IDEA (Early Intervention)** handout and slides **(H7, page 70/Slides 33- 36)**
  - Statewide Public Awareness
    - ✓ Created through brochures, videos, toll-free numbers
  - Child Identification
    - ✓ School district Child Find or local interagency teams
  - Central Directory of Resources
    - ✓ Early Intervention Colorado (eicolorado.org) and local web sites Data Collection
    - ✓ # of children & how they are served
  - Personnel Development/ Standards
    - ✓ Includes Preservice and inservice training
    - ✓ The purpose of personnel development is to ensure qualified personnel are supporting children and families within the early intervention system. This certification program is an example of personnel development. Another dimension of personnel development is having policies and procedures to insure that the highest qualified staff provides services and supports.

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- Evaluation and Monitoring
  Includes Onsite monitoring, desk audit, and focused monitoring
  - ✓ Onsite monitoring: community visit where files are reviewed – findings are shared at exit interview and by report
  - ✓ Desk Audit: data is reviewed to determine level of compliance with federal indicators
  - ✓ Focused monitoring: based on desk audit review, involves staff and administrator interviews and file reviews
- Equitable Distribution of Resources
  - ✓ In Colorado, funds are distributed to 20 regional community center boards (CCBS).
  - ✓ Based on formula from state Division of Developmental Disabilities (using data from Community Contract Management System- CCMS).

Note to the instructor: *Remind the participants this is a good opportunity to use their Alphabet Soup card. Also remind the participants we will learn about these new terms in detail in a bit*].

- Child and Family Entitlements
  - ✓ Multidisciplinary Evaluation & Assessment
  - ✓ Individualized Family Services Plan (IFSP)
  - ✓ Service Coordination
  - ✓ Provision of Services in Natural Environments
  - ✓ Procedural Safeguards (Family Rights)

- Highlight that IDEA requires that child and family entitlements must be provided at no cost to families

Goal 3: Describe the organizational structure that enables the implementation of Part C of IDEA in Colorado

3.1 Lecture: Who is Responsible for Part C in Colorado?

- Show **Organizational Structure for Part C Services in Colorado** slide (**Slide 37**) and inform the participants that we will look at what state and local entities are responsible for the delivery of Part C services in Colorado.

- Use **Who is Responsible for Part C of IDEA in Colorado?** handout and slide **(H8, page 71/Slide 38).**

- Explain that the Governor of each state designates the lead agency for Part C. In about one-third of the states, the State Department of Education is the lead agency, in about one-third, the State Department of Health is the lead agency, and in about one-third it is some other lead agency, for example State Department of Developmental Disabilities, Social Services, Office of Children and Youth, etc.

- State that in Colorado, there are responsibilities at both the state as well as local levels and explain that:

- The Colorado Department of Human Services (CDHS), Division for Developmental Disabilities (DDD) is the lead agency for Part C in Colorado, and the program is referred to as Early Intervention Colorado. The IDEA Part C funds come from the federal Office of Special Education Programs (OSEP) to CDHS/DDD.
- The Colorado Interagency Coordinating Council (CICC) acts as the advisory body to the DDD. The CICC consists of appointed representatives of a variety of statewide stakeholders – parents, providers, representatives of other state agencies involved in early intervention services and other entities (e.g., Department of Health and Human Services, Division of Insurance, Head Start, Protection and Advocacy agency, etc.).
- DDD contracts with twenty Community Centered Boards (CCBs) to deliver community-based services to adults and children with developmental disabilities. These CCBs, located in rural plains, mountain communities, and cities along urban corridor, are private non-profit organizations designated by the state as the single entry point into the long-term service and support system for persons with developmental disabilities. DDD disperses the IDEA Part C funds, along with state early intervention dollars to the 20 local Community Centered Boards.
- DDD requires that each CCB have a Local Interagency Coordinating Council (LICC) that provides the interagency collaboration and advisement necessary to effectively implement early intervention services. The CCBs provide service coordination and direct early intervention services to eligible children and their families through their early intervention staff (including DI Assistants) or contract with independent providers or use a combination of staff and contract providers.

- Inform participants that if they want to learn more about the above, he information, they can be found on the Early Intervention Colorado website eicolorado.org website. http:/www.eicolorado.org/index.cfm?
  Note to Instructor: Check link before using them to be sure the link is working.

3.2 Lecture: Where do DI Assistants fit in Part C organizational structure?

- Using **2004 Re-authorization of IDEA: Requirement for Paraprofessionals** slide **(Slide 39)** point out the requirements of the paraprofessionals as per the IDEA.
  - The State educational agency establishes and maintains standards to ensure that paraprofessionals and assistants are appropriately and adequately trained and supervised.
  - SEC 635: The State has a comprehensive system of personnel development, including the training of paraprofessionals … 612(a)(14
  - SEC. 653. The State improvement plan shall address the identified needs for in-service and pre-service preparation for all personnel (professional and paraprofessional …… (ii) prepare professionals and paraprofessionals in the area of early intervention with the content knowledge and collaborative skills; (iii) to participate in pre-service and in-service training

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- Develop career opportunities for paraprofessionals to receive training as special education teachers, related services personnel, and early intervention personnel

- Show **Definition of DI Assistant** slide (**Slide 40**) and explain that in Colorado, Developmental Intervention Assistant (DI Assistant) is the title used for some paraprofessionals in early intervention. This title was established by a statewide coalition coordinated by Early Intervention Colorado under its Comprehensive Training Opportunities for Paraeducators for Early Intervention services (CO-TOP*EIS) Project. The coalition established the following definition for the DI Assistant:
  Developmental Intervention Assistant ***(DI Assistant)*** provides *Developmental Intervention services to families, infants and toddlers **under the supervision of a qualified early intervention provider** who has completed *Developmental Intervention Supervisor Academy (DISA).

* DISA is a two-day training that enables the CCB nominated early intervention providers to expand their communication, collaboration, problem solving and supervisory skill needed to work with DI Assistants.

- Explain that Developmental Intervention includes services that address the functional developmental needs of an infant or toddler with a disability, as identified by the family, in the areas including, but not limited to the following:
  - Motor Development (use of hands and movement of body)
  - Communication Development (understanding and use of gestures, speech and language)
  - Cognitive Development (playing, thinking, and exploring)
  - Social/Emotional Development (relating to others)
  - Adaptive Development (eating, dressing, and toileting)
- Inform them that they will be learning about the above developmental areas or domains later in this academy.

- Remember to highlight the underlined words and emphasize that in compliance with the law, the DI Assistant always works under the supervision of a qualified/licensed early intervention provider (e.g. special educator, speech language pathologist, occupational therapist, etc). Point out that the role of the DI Assistant is different than that of the early intervention provider and they will learn more about their role and that of their supervisor (i.e. the early intervention provider in the supervisory position) in the **III. Early Intervention Teamwork Academy.**

- Inform the participants that the DI Assistants are required to complete a training which consists of 15 courses or academies. The completion of this training enables Early Intervention Colorado to meet the requirements of IDEA to provide professional development and training for the DI Assistant to be able to provide effective services to infants and toddlers and families. The CO-TOP*EIS project also provides training to qualified early intervention provider to become effective supervisors and trainers of DI Assistants. Additionally, while the focus of the CO-TOP*EIS Project is to prepare DI Assistants (aka paraprofessionals) for their current role, it also opens doors for them further their education at a community college and/or pursue graduate degrees in specialty areas of interest ultimately leading them to a career as a specialized service provider.

Goal 4: Discuss the core values and concepts that guide early intervention services under Part C of IDEA

4.1 Lecture: Colorado Interagency Coordinating Council Vision and Principles

- Use **Colorado Interagency Coordinating Council Vision** slide **(Slide 41)**
- Explain that the statement on the slide that was created by the members of the CICC (e.g. CDE/ECC, Health, DDS/CCB's).

  CICC Vision*: "The Colorado Interagency Coordinating Council will support a wide range of activities that promote inclusive communities that enhance participation and the growth, development, and quality of life for children birth to three and their families in a culturally competent manner*."
- Highlight the key words that are underlined: "*promote inclusive communities"; enhance "quality of life";* and *"culturally competent"*.
- Remind them that we will look at each of them one by one later.
- Explain that the following 7 guiding principles have been identified by the early intervention system as a foundation for EI supports and services. All EI supports and services should reflect them. Show **Colorado Interagency Coordinating Council (CICC) Guiding Values** slides (**Slides 42-47**) and read each principle aloud.

1. Children and families are valued for their unique capacities, experiences, and potential.
2. Families have the right and responsibility to make decisions on behalf of their children and themselves.
3. Parent leadership is valued as an essential aspect of the statewide system of early intervention.
4. Communities are enhanced by recognizing and honoring the diversity among all people.
5. Families make the best choices when they have comprehensive information about the full range of formal and natural resources in their communities.
6. Creative, flexible, and collaborative approaches to services allow for individual child, family, and community differences.

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4.2 Large Group Activity: Colorado Interagency Coordinating Council (CICC) Guiding Values

DI Assistants will participate in the following activity to reflect on what each of the guiding values mean to them when providing services to infants and toddlers with disabilities and their families.

4.2.1 Steps

- After reviewing **Slides 42-47** above, distribute handout **Colorado Interagency Coordinating Council (CICC) Guiding Values** handout **(H9, page 72**) to the participants.
- Use **Activity: CICC Guiding Values** slide (**Slide 48**) to give directions to the participants.
- Review the six guiding values one by one on each slide and the handout **(H9, page 72/Slides 42-47).**
- For each value give an example or seek one from the participants.
- Ask the participants to write the key words for each value on their handouts.
- Finally, summarize these slides: These guiding values establish the expectation that all early intervention practices will be family-centered.
- Ask for any questions, address any that are asked, and then proceed to the next activity.

4.3 How are Early Intervention Services Delivered?

- Remind participants of Colorado's vision for early intervention services from **Colorado** Interagency **Coordinating Council Vision** slide **(Slide 41)** and **Colorado Interagency Coordinating Council (CICC) Guiding Values** handout **(H9, page 72**)

  CICC Vision*: "The Colorado Interagency Coordinating Council will support a wide range of activities that promote inclusive communities, that enhance participation and the growth, development, and quality of life for children birth to three and their families in a culturally competent manner*."

- Read **How are Early Intervention Services Delivered?** slide (**Slide 49**).

- Ask the participants- do they see any similarities between CICC's vision and how the federal law suggests the services should be delivered? Prompt the participants to look for the key underlined words in both the statements. Emphasize that the federal law reflects family-driven practices as well.

- Inform that now you are going to look at some key concept in provision of early intervention services. Tell them that these are: natural environments, the transdisciplinary/primary provider model and family centered practices.

4.4 Discussion: Natural Environments

- Read from the slide **Natural Environments** (**Slide 50**).
  Natural environments are the places including the home, and community settings in which children without disabilities typically participate, live, learn, and play.

- Ask the participants for some examples of natural environments.

- Wait until you have about 3 or 4 examples.

- Show **Examples of Natural Environments** slide (**Slide 51**).
  - home
  - gymnastic programs
  - parks
  - neighbor's homes
  - neighborhood play groups
  - toy lending libraries
  - museums
  - church
  - swimming pools
  - family hikes
  - mommy and me classes
  - child care
  - birthdays and other family celebrations
  - fast food restaurants (and play spaces)
  - book stores and library story hours

- Ask the participants for some examples of daily routines that occur in an infant/toddler's natural environment.

- Wait until you have 3 or 4 examples.

- Using **Daily Routines in Natural Environments** slide (**Slide 52)**, tell the participants that these are some routines typically occur in the natural environments:
  - brushing teeth
  - diapering
  - meal time
  - playing with siblings
  - playing with neighbors
  - watching TV
  - folding laundry
  - reading stories
  - nap time

  - Emphasize that:
  - Every child, family, and community is different. What is a natural part of one family's routine may never happen in another family.

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- An environment is not "natural" if it was invented to meet the special need of the child or children.
- An environment is not "natural" if a provider or someone outside the family determines that the child or family "should" participate.

- Using **Participation in families' everyday routines, activities, places, and relationships** slide **(Slide 53)**, explain to the participants that participation in families' everyday routines, activities, places, and relationships include:
  - Providing supports and services within the **context** of families' lives.
  - Supporting child and family **participation** in everyday life.
  - Creating **functional** rather than developmental outcomes.
  - Supporting that which happens **between visits**.
  - Being guided by the context of a child and family's everyday life and the families' goals for their child's **participation, independence, and learning.**

4.5 Discussion: Home Visiting

- Tell the participants that one of the common modes of service delivery is through home visits.

- Ask them to raise their hands if they have been to any home visits. Be sure to support the use of strengths-based, non-judgmental language.

- Request one or two volunteers to share their experience of a home visit briefly

- Allow for comments or questions from other participants

- Using **What is Home Visiting?** slide **(Slide 54)** and explain to the participants that:
  - Home visiting is a "process by which a professional or paraprofessional provides support and information to a family in their own home."
  - Home visiting can different forms – it can be the only mode of services or it can be a part of any array of services or it can be primarily as a communication vehicle

- Distribute **Providing Services in the Natural Environment** handout **(H10**, **page 73** that summarizes the discussion on natural environments.

- Using **Prerequisites for Home Visitors** slide (**Slide 55**) and **Providing Services in the Natural Environment** handout (**H10**, **page 73)** discuss some of the dispositions and skills the home visitor must possess.

- Ask the participants to reflect on and share with the group:
  - Why some of these skills like sense humor may be important in home visiting.
  - What would a good child interaction skill look like?
  - Why is skill in observation necessary?
  - What benefits can introspection or self examination bring?
  - What does "ability to accentuate" the positive mean to them?

4.6 Lecture: The Primary Provider/Transdisciplinary team model

- Explain that Transdisciplinary team is another critical component of early intervention service delivery.

Note to Instructor: In order to discuss the next few slides on Transdisciplinary teams, please order/ download the "**Transdisciplinary Team/Primary Service Provider Model".** The brochure can be downloaded at http://www.eicolorado.org/Files/Transdisciplinary_PSPBrochure_FINAL.pdf?CFID=7923341&CFTOKEN=83131318
Check link before using them to be sure the link is working.
The brochures can be ordered at Early Intervention Colorado by visiting their website: www.eicolorado.org or calling 1-888-777-404.

- Using **Slides 56 & 57** and **Transdisciplinary Team/Primary Service Provider Model** handout **(H11, page 74)**, explain to the participants what transdisciplinary team means and what does a transdisciplinary early intervention look like. Review the following information from the handout under "**What does transdisciplinary early intervention look like?**"
  - The team relies on the family. An initial conversational interview with a member of the transdisciplinary team is set up to learn about the routines of the child and the family. In many cases, this is the service coordinator for the family.
  - Based on this interview, the family decides, along with the Individualized Family Service Plan (IFSP) Team, what their main concerns and priorities are and how those will be addressed. The child's IFSP, including the determination of supports and services, is based on the outcomes of this meeting.
  - At the IFSP meeting, a primary service provider, who is determined by the team to be the best fit for the child and family, is designated. This team member is the primary contact between the family and the transdisciplinary team.
  - There is regular contact between the primary service provider and the transdisciplinary team. There is regular communication among the family, service coordinator, and primary service provider to judge how well the early intervention is working. The team, including the family, will adjust the amount and type of services if necessary.
  - Having a primary service provider reduces the number of professionals and visits that a family has to have in their home.
  - The primary provider meets with the family to focus on ways the family can support the child's development within their everyday routines, activities, and places (ERAP). In addition, the primary provider gathers ideas to support the child and family from the team meetings with other providers. In this way, the family and child benefit from the expertise of the entire team of providers.

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4.7 Lecture: Family Centered Practices & Cultural Competence

- Mention to the participants that two other important aspects of service delivery in early intervention are *family centered practices* and *cultural competence*. They will learn about it in great detail in **Academy II: Fundamentals of IFSP Process** as well as **Academy IV: Working with Families.**

4.8 Large Group Activity: Get Ready to Play

The purpose of this activity is to review the key information that the DI Assistants have learned in Module A in a non-threatening, fun way by playing "Who Wants to Be a Millionaire." (Take about 30 minutes to do this.)

4.8.1 Steps

- Show **Get Ready to Play** slide (**Slide 58**) and inform participants that they will now be playing *Who Wants to be a Millionaire*?
- Show **Sequence Events Chronologically** slide (**Slide 59**) and tell people that they need to sequence these events as quickly as possible by writing the letters on a paper... Be sure to reinforce that each person needs to do this individually – no conferring with your neighbor!
- After everyone has completed this, show **The correct answer is….** slide (**Slide 60) and** have all participants that answer correctly pick a number out of the bowl. The person with the lowest number will be the first contestant to attempt to become a DI Assistant Millionaire! If that person should answer incorrectly, the person with the next lowest number goes next, and so forth.
- Show **Do You Know the Rules***?* slide (**Slide 61**) and tell the participants- "Here's how it goes. You get DIA millionaire dollars for each correct answer. IF you miss, you go back to zero and are eliminated and the next player takes your spot. There are some "safe" spots. IF you reach $1000, you can't go home with less. If you reach $32,000, you can't go home with less than this. But try to reach $1,000,000, because then you are an official DI Assistant MILLIONAIRE!"
- Show **Lifelines** slide (**Slide 62**) and explain the life lines. Tell the "audience" that this activity is an "open handout" exercise for them and they can refer to the materials that were used throughout Module 1. However, keep a watch on the time.
- Follow **Slides 63- 92**. Note that:
  - Each slide is arranged such that the first slide is the question, followed by the answer slide.
- Go through the rest of the slides (through **Slide 92**).
- Keep the show upbeat and ENJOY!!!

4.9 Individual Activity: Post Quiz: Module A

This activity will help DI Assistant assess their knowledge of content covered in Module A. Consider this a "posttest".

4.9.1 Steps

- Show **Post Quiz Module A** slide (**Slide 93**) and ask the DI Assistants to pull out the quiz (**H4, page 67)** they had completed at the beginning of the Module.

- Ask the participants to review their answers from last time and make changes to correct the responses based on their new learning.

- After the participants have had a chance to review and correct their answers show **Correct Answers Are……**slide (**Slide 94**).

- The questions and correct responses on the quiz are as below.

  Q1. What does IDEA stand for?
  - Individuals with Disabilities Education Act

  Q2. When did the last authorization of IDEA take place?
  - 2004

  Q3. Which part of the IDEA covers Early Intervention services for infants and toddlers and their families?
  - Part C

  Q4. The federal government requires that the governor must designate a lead agency to receive the grant and administer the program to provide early intervention services for infants and toddlers with disabilities and their families. Which state agency has been designated "lead agency" in the state of Colorado?
  - Colorado Department of Human Services/ Division for Developmental Disabilities

  Q5. What is the purpose of the Colorado Interagency Coordinating Council (CICC)?
  - To advise the lead agency for infant toddler services in Colorado on how to implement the services.

- Show **You Rock!!** slide (**Slide 95)** and end with the final slide and praise them and tell them how wonderful they have all done!!

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Module B: Overview of Child Development

Note to the instructor: If you are covering this on a different day or after a short break, welcome the participants to the session and revisit the group norms agreed upon at the beginning of Module A.

A. Recap of Module A

- Using **Recap of Module A: History, Legal Precedents, and Values of Early Intervention Services** slide (**Slide 96);** remind The DI Assistant what they had covered in the previous module.

  Module A covered History, Legal Precedents, and Values of Early Intervention Services You learned about:

- Show **Slide 97** and inform the participants that we will be starting Module B next.

B. Module B Goals

Use **Slide 98** and **Module Goals** handout **(H1, page 64)** to review the goals of Module B. In this module, DI assistants will:

1. Identify major motor, communication, cognitive, social/emotional, and adaptive milestones
2. Recognize the risk factors that may prohibit or impede typical development and the protective/resiliency factors that may counteract these risk factors
3. Discuss the importance of the relationship between child development and the concepts of developmental delays and disability.

C. Energizer

- Show **Slide 99** and ask the participants to answer the question #1:
  How many babies are born in the United States each year?

- Acknowledge their answers and show **Slide 100** with the answer to the question:
  Over 4 million babies are born in the US each year.

- Show **Slide 101** and ask the participants to answer the question #1:
  How many infant toddlers (birth to age three) are living in the US?

- Acknowledge their answers and show **Slide 102** with the answer to the question:
  11.4 million Infants and toddlers (birth to age three) are living in the US.

- Highlight that there is research to support that early intervention and care have long term benefits for children and families.

D. If Babies Came with Manuals

- Show **Slide 103** and watch "If Babies Come with Manuals" on PBS. The "video" picture has the hyperlink. If you click on the picture in the "slideshow mode", it should take you to the website. The website link is: http://www.pbs.org/parents/earlylearning/babycues.html.

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NOTE: Internet access is necessary. If you will not have internet access, please download the video from the link onto your computer prior to beginning and create the link on the slide to this video. Make sure that the video and the PowerPoint slides remain in the same folder for the hyperlink to work. Check link before using them to be sure the link is working.

- Seek comments from participants.
- Stress that children are active learners and emphasize the importance of not promoting a milestone approach. Discuss how children learn through active learning. Create a sense of awe for children's ability to learn.

Goal 1: Identify major motor, communication, cognitive, social/emotional, and adaptive milestones

Show **Slide 104,** mention to the participants that will now learn about the relationship between child development and early intervention.

1.1 Lecture: Understanding Child Development

- Using**, Why Do We Need to Know About Child Development?** slide **(Slide 105),** emphasize to the participants that:
  - Learning about child development is important in order to support families in keeping the IFSP and how services are delivered strengths-based. It's not all about what their child cannot do. Sometimes families and professionals get focused on what the child cannot do. E.g. "He can't walk." We need to help families understand that all children, including those with special needs, grow and develop at their own pace and all children have strengths.
  - Understanding of child development is also important so that we can see if a child is performing as well as, or below their peers. With this understanding we can provide "developmentally appropriate" interventions to children.

1.2 Discussion: Seeing the Whole Child

- Show **Seeing the Whole Child** slide (**Slide 106**) and explain to the participants that, though each professional may work with specific domains (e.g. speech language pathologist may work on the child's language and communication) – it is critical, particularly in early intervention that all professionals providing service see the whole child.

- Show **Severely Dysfunctional Team** cartoon **(Slide 107)** and ask the participants, "What is wrong with this picture? Why would this be considered a severely dysfunctional team?"
  Source: Cartoons from Ants in His Pants: Absurdities and Realities of Special Education & Flying by the Seat of Your Pants: More Absurdities and Realities of Special Education by Michael F. Giangreco & Kevin Ruelle

- Encourage participants to respond that any professional who works with children by their specific domains alone (e.g. speech therapist focusing on the development of the oral muscles or the physical therapist working on gross motor skills), instead of thinking and planning for the child as a whole, will not adequately meet the child's or family's need. Remind them of the transdisciplinary approach to early intervention they had learned about in Module A of this academy earlier.

- Further, remind them that they will learn about working in teams with other professionals in Academy III, Early Intervention Teamwork.

- Using **Slide 108**, highlight to the participants that every baby is unique. We need to make sure that we look at them holistically, considering the interrelatedness of all the domains of development

- Using **The Various Parts** handout and showing slide (**H12, page 75/Slide 109);** explain that development of children is influenced by multiple factors. For example:
  - Family context and relationships within the family play a great role in the development of the child. By family context and relationships we mean- is it a nuclear family with both parents? Single parent family? Family where grandparents have a role to play in the infant or toddler's development? Does the infant/ toddler have siblings? What is the birth order of this child? Are the parents of the infant/ toddler the first time parents?
  - Culture of the family influences child's development greatly. The DI assistants will learn more about the influence of culture on child's development in Academy IV, Working with Families.

  Genetics, biochemistry, physiology are each responsible for the development of the child

- Using **The Various Parts** handout and **Developmental Domains** slide **(H12 page 75/Slide 110)** mention to the participants that following are the five domains:
  - Motor Development (use of hands and movement of body)
  - Communication Development (understanding and use of gestures, speech and language)
  - Cognitive Development (playing, thinking, and exploring)
  - Social/Emotional Development (relating to others)
  - Adaptive Development (eating, dressing, and toileting)

  These five domains of development reflect the standard manner of dividing the study of child development and are reflected specifically on the Colorado IFSP in this order

- Show **Important Question"?** slide (**Slide 111**) and ask the participants, **"Why do you think we talk about children in "domains?" What are the benefits?**

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- Encourage participants to suggest a couple of reasons. Then move to the **Why do you think we talk about children in "domains?"** slide (**Slide 112**) to explain what may not have been covered or to emphasize the points that the participants may have shared.
  - Human development is multifaceted and remarkably complex.
  - We divide development into domains so we can more easily understand and talk about it.
  - When looking at the characteristics that make up a child, we have to not only looked at the major domains individually, but also at how each of those domains interact with each other.

- Highlight the fact that based on this rationale, suggested by researchers, practitioners, family members, and policy makers- IDEA mandates that we look at all these domains.

1.3 Interactive Lecture: Principles of Development

- Use **Principles of Development** handout and slide **(H13, page 76/Slide 113).** Remind participants that now that we have a fair understanding of the importance of child development, we will transition to learning about principles of development. During this interactive lecture, encourage participants to take notes in their handouts.

Principle 1 – Development is sequential and occurs in bursts and plateaus **(Slide 114).**

- Explain to the participants that:
  - The sequences of development are predictable.
  - Most children will reach developmental milestones in this predictable sequence – some develop faster and some develop slower. For example, you have to crawl before you can walk. Encourage the participants to share other examples. (e.g. Single words occur before sentences)
  - Sequences are documented in developmental checklists and "milestones."

Principle 2 – Development is interdependent **(Slide 115-116).**

- Explain to the participants that:
  - Progress in one developmental domain influences progress in other domains. Use **Example of Principle 2** slide **(Slide 116)** and explain that all of the "parts" of a child are connected, and all of the parts respond to each other. For example, as a child's oral motor skills increase so does his or her capacity to speak clearly. As the child's gross motor skills increase, the capacity to explore their environment is expanded, so their novel experiences increase, which in turn will lead to increased knowledge base, word use, understanding of language, etc.
  - Thus, very often a child may make rapid advances in one domain because they are building from strengths in another domain.
  - This can also work in reverse. A child may fail to progress in one domain because of challenges in another.

- Ask the participants if they can think of any examples when a lack of growth in one area can impede development in the other areas?

- Praise them for their examples and suggest one of your own. For example, the child with cerebral palsy may have typically developing cognitive abilities, but he may be constrained in exploring the environment because of motor disabilities. This motor disability can impede progress in socialization, intellectual pursuits, etc.

Principle 3- Development is influenced by nature and nurture

- Use **Slides 117-119** to explain to the participants that:
  - Children grow and develop in the context of relationships with their families and other caregivers, the cultural beliefs of the family, and the temperament that the child brings to that.
  - "Windows of opportunity" for learning have been documented for the first three years of life for all areas of development. Areas of the brain evolve in a predictable sequence. The timing of these developmental changes explains, in part, why there are "prime times" for certain kinds of learning and development (Shore, 1997, p. 16). Parents and caregivers can support these prime times of development, or 'windows of opportunity', by providing a range of experiences for infants that will strengthen their development. Vision, language, motor skills, math, logic and music, feelings and emotions, all have 'windows of opportunity' – some last weeks, others last years. Therefore early intervention has greater impact on development while the brain is still growing at this stage.
  - The early environments and experiences play a critical role in brain development. The right amount of stimulation is critical. Therefore, it is critical that infants and toddlers be exposed to multiple opportunities for learning and exploring their environment at an early age...
  - Example: If a parent learns ways to position their child with cerebral palsy as the child is learning to move their body; that movement can become more effective as the child continues to develop. If not intervened early, the child may learn atypical movement to compensate for lack of motor control.
  - Although cultural differences will influence the child's development and may cause the process to appear delayed, the child may still be developing within the normal sequences.
  - However, if something is impeding the overall development in a certain domain, the child may still need early intervention regardless of the cultural influences.
  - Thus, it is important to look at the child in the context of their family relationships in order to develop effective strategies for intervention.
  - Differences are also influenced by relationships: For example, a mother that picks up a crying baby teaches a baby that is a safe place that the baby's needs get met and lays the foundation for positive future social-emotional development.
  - Provide a research example: Mahoney and Powell (1988) found that infants with disabilities whose mothers allowed them to take the lead and supported child-initiated activities had improved developmental outcomes.

Principle 4- Development occurs differently for different children

- Use **Slides 120- 122** to explain to the participants that:
  - In looking at when a child gains a certain skill, we need to remember there is a wide range of what is considered "typical". For example, children may say their first words anywhere between 9 to 15 months of age or walk between 9 to 16 months of age. Remind them that in a little while, we will discuss in detail the range of typical development.
  - Also highlight that there are personality differences in how children develop. In the same household, no two children are alike. For example, one child may be a social talker while others speak in monosyllables. Encourage participants to share examples of how similar and different their own siblings' or their own children's' personalities developed.

1.4 Activity: Child Development

The following series of activities will help the DI Assistants learn about and practice identifying developmental milestones in young children in all domains.

1.4.1 Steps:

- To introduce the topic of child development, first watch the video in **Child Development Video #1** slide (**Slide 123**) from Centers for Disease Control (CDC) to review some developmental milestones in young children. The link http://www.cdc.gov/CDCtv/BabySteps/ – will take you to the web-site. This video is 4:32 minutes.

Note to Instructor: Internet access is necessary. If you will not have internet access, please download the video from the link onto your computer prior to beginning and create the link on the slide to this video. Make sure that the video and the PowerPoint slides remain in the same folder for the hyperlink to work.

- Have participants share what they learned regarding milestones from the video.

- Lead them into the next activity by telling them that they are going to learn more detailed information with regards to milestones.

1.5 Activity: Milestones in Young Children (30 minutes)

The following series of activities will help the DI Assistants learn about and practice identifying developmental milestones in young children in all domains.

1.5.1 Steps:

- Distribute **Developmental Milestones** handouts (**H14a-e, pages 77-81**) to all participants. Share with them information about the handout. Tell them that these handouts and other useful materials are available on the CDC website. http://www.cdc.gov/ncbddd/actearly/milestones/. The address for this website is available within the handouts.

Note to Instructor: Check link to be sure it is working.

- Tell the participants that they will need these handouts for the current activity and then again when they complete the next activity.
- Give the participants 10 minutes to glance through the 5 handouts. Ask them to think about any familiar children between 0-36 months (niece/ nephew/ their own children/ a child in their center etc.) as they review these handouts.
- Allow them another 10 minutes to discuss the 5 handouts with a partner.
- After 10 minutes attract their attention back to the presentation.
- Explain to the participants that now we will practice identifying developmental milestones from the handouts.
- Move slowly between slides 124-128 allowing participants to grasp the content of the slide, review the Developmental Milestones handout to find the correct response, and share the response with the peers.
- In each of the slides, ask the questions on the slide.
- Allow participants to look for the answer in the Developmental Milestones handouts **(H14a-e, pages 77-81)**.
- Have volunteers share the answer aloud.
- Below is the answer key for the questions.

  Answer Key:

  Motor Domain:
  - Q1- When does the child begin to transfer an object from one hand to another? Why is this skill important in later physical development? Can learning in any other domain benefit from this?
    - *A1: by around 7 months, children can transfer objects from one hand to another.*

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- Q2- Richa is 34 months old. She can stand by herself, and walk with a broad based gait. She crawls up the stairs. Richa's parents are worried that she is not running and doing things other children in her preschool her age are doing. Is their concern justified?
  - *A2: Yes. Typically at around 34 months children can climb stairs with support, run, and kick a ball.*

Communication Domain:

- Q1- At what age do children typically turn their head towards the direction of sound?
  - *A1: By three months children can locate the direction of sound*
- Q2- When do children begin to use 2-4 word sentences?
  - *A2: By about 24 months children can string 2-4 words to make sentences.*
- Q3- Rosina is two years old and does not follow simple instructions such as "Rosina, come here." Should Rosina's parents be worried?
  - *A3: Possibly. Typically children start to follow instructions at around 24 months. If Rosina is showing delay in other areas as well, Rosina's parents should contact their pediatrician to get a referral for screening in their local child find program.*

***Cognitive Domain**:*

- Q1- When do children start to find partially hidden toys?
  - *A1: By about 6 months children can find a partially hidden object that was hidden while they were watching.*
- Q2- Josh can match pictures with their names, is starting to babble with intonation or varying of pitch and imitates gestures. How old do you think Josh is?
  - *A2: Looking at the multiple signs of development, Josh is probably about 12 months old.*
- Q3- 32 month old Mark can complete 10 large pieces puzzles of cars and airplanes. Is his development typical?
  - *A3: Mark is performing at a higher level in puzzle making skills. Other areas/ skills should also be considered before coming to a conclusion about his overall ability. It could also be that Mark has had repeated exposure to these specific puzzles and therefore can perform well beyond his age on them.*

Social/ Emotional Domain:

- Q1- When do children start becoming interested in mirror image? How does this learning impact other domains?
  - *A1: by around 7 months, children can identify themselves in a mirror. This milestone is critical to children's later understanding of "self" and "self-esteem".*
- Q2- When do children begin to smile socially?
  - *A2: By about 3 months children smile when adults smile at them*

- Q3- At what age do children typically demonstrate stranger anxiety?
  - *A3: Between 10- 12 months children typically demonstrate anxiety towards strangers.*

Adaptive Domain:

- Q1- When do children typically begin picking up and eating Cheerios and other small finger foods?
  - *A1: By the end of 12 months children can pick up small food while sitting comfortably on their high chair or on mother's lap or on the floor.*
- Q2- What are some of the adaptive skills you would observe for an infant or toddler?
  - A1: DI Assistants may look at the child's feeding and observe: (a) Does the child use tongue and lips to take and swallow solid food? (b) Can the child bite and chew solid food? Does the child drink from a cup when helped by an adult or when the child holds it himself/ herself? Can the child transfer food between containers?
  - DI Assistants may also observe the child's sense of hygiene: does the child demonstrate bladder or bowel control? Can the child indicate awareness of soiled or wet pants? Does the child cooperate when brushing?
  - DI Assistants may also observe if the child can take off loose pieces of clothing such as a sweater or unfastened coat or jacket.

1.6 Activity: Let's Watch a Video!!

This activity focuses on developing observational skills as well as enhancing the understanding of different domains of child development.

1.6.1 Steps:

- Show **Child Development Video #2** slide (**Slide 129).** The link to this video is provided in the slide as well as below.
  (This video is available at: http://abavtooldev.pearsoncmg.com/myeducationlab/singleplay.php?projectID=mcdevitt.ormrod&clipID=Cognitive_Development_Infancy.flv)

***Note to the instructor*:** Internet access is necessary. If you will not have internet access, please download the video from the link onto your computer prior to beginning and create the link on the slide to this video. Make sure that the video and the PowerPoint slides remain in the same folder for the hyperlink to work.

This is a 2:48 minute video and includes subtitles. Before you begin the video, ask the participants to pay special attention to what they see in each area- Physical, Language, Adaptive, Cognitive.

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- After viewing the video – encourage participants to share what they saw. Highlight some of these domains in the conversation:
  - Motor – point out the fine motor and gross motor skills displayed in this video
  - Communication – what is the child's expressive language? What is the child's receptive language?
  - Cognitive – can the child identify the object? Can the child understand object permanence? Cause and effect? Can the child follow simple commands?
  - Social/ Emotional- does the child display affection toward familiar adult and demonstrate attachment for the caregiver? Observe if the child repeats sounds and gestures to get attention? Does the child initiate and/ or respond to communication from familiar adult? Does the child demonstrate extended amount of on-task behaviors when he is interested in the toy.
  - Adaptive – ask the participants, "Based on the child's motor skills what would you expect the child to be able to do in terms of feeding himself, or dressing?"
- Inform participants that this ends Goal 1 of the Module B where they learned about child development and major cognitive, communication, social emotional, motor, and adaptive milestones. Show **Slide 130** and let them know that in the next section of this module, participants will learn about the risk or resiliency factors that may prohibit or impede typical development.

Goal 2: Know the risk factors that may prohibit or impede typical development and the protective/resiliency factors that may counteract these risk factors

2.1 Activity: The Resiliency Quiz

The purpose of this activity is for the DI Assistant to complete the resiliency quiz and identify their own resiliency and factors that build resiliency.

2.1.1 Steps:

- Ask participants how they would define the word resilient?
- State that the word resilient is really a scientific word referring to a material that does not bend or break.
- Explain that now the word describes people's personalities. That resilient people have stress-resistant personalities and learn valuable lessons from rough experiences. Resilience is the process of successfully adapting to difficult or challenging life experiences. Resilient people overcome adversity, bounce back from setbacks, and can thrive under extreme, on-going pressure without acting in dysfunctional or harmful ways.

- Use **The Resiliency Quiz** handout and slide (**H15, pages 82-85/Slide 131**).

- Ask the participants to complete the quiz for themselves. Give the participants about 10 minutes to complete the quiz.

- After ten minutes are over, ask the participants to pair with the participant sitting next to them and discuss the following questions:

  a. What are some of strengths they see in themselves that help them be resilient?
  b. How can they improve their resiliency?
  c. What can they do to help a friend/loved one become more resilient?
  d. How will this knowledge about their own resiliency help them in their work with families and infants/toddlers?

- Share with the large group.

- Highlight that the most resilient people recover from traumatic experiences stronger, better, and wiser.

2.2 Interactive Discussion: Risk, Resilience, and Protective factors

Note to Instructor: This is an introduction to risk, resilience and protective factors. These concepts will be repeated in depth in Academy IV. Working With Families Academy which has case studies that participants will read and identify these factors.

- Distribute **Risk, Resilience, and Protective Factors** handout **(H16, page 86).**

- Show **Risk** slide **(Slide 132)** and explain that risk refers to the presence of one or more factors that increases the probability of a delay in a child's development.
  Risk may be caused due to:
  - Biological factors -may be genetic or inherited traits from parents- ask participants to give examples of biological factors that they think they inherited from their parents or grandparents?
  - Ecological factors -may be environmental factors that relate to the person and their environment, for example person who was born in another country than moved to the USA when they were two or children born in a poor or in a wealthy neighborhood.
  - Combined biopsychosocial factors draw upon the **biopsychosocial model** (abbreviated "BPS") which is an approach that states that biological, psychological (which entails thoughts, emotions, and behaviors), and social factors, all play a significant role in human functioning in the context of disease or illness. Indeed, health is best un-

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derstood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms
(i.e. factors that may be biological or ecological in nature primarily but may have influence on the other factors as well).
(Richman & Fraser, 2003)

- Ask participants to list and share (a) Biological factors, (b) Ecological factors, and (c) Combined biopsychosocial factors that may predict negative outcomes for young children.
  Show **Examples of Risk Factors** slide (**Slide 133**) to sum up the discussion:
  - *Biological risk factors*: Chronic health conditions, prenatal exposure to toxic substances, disabilities, low birth weight, prematurity, poor health.
  - *Ecological risk factors*: neighborhood violence, parents who are incarcerated, parents who are not literate, parents who work, factors of abuse and/or neglect, the experience of homelessness or poverty, domestic violence, divorce etc.
  - *Combined biopsychosocial factors:* Parental mental illness, parental disability (may be genetic in nature and increase the chances of disability/ mental illness in the child)

- Show **Protective factors** slides (**Slides 134-135**) and go over the content:
  - Protective factors are characteristics or conditions that counteract the risk to which children are exposed
  - Protective factors delay, suppress, or neutralize negative outcomes
  - Protective factors sometimes provide a buffer against the risk.
  - Protective factors are important because they provide clues for designing more effective social programs that lessen the risk.
  - Three categories
    - individual factors (e.g. tenacity, optimism, openness)
    - familial factors (e.g. parental support, supervision)
    - extra-familial factors (e.g. community networks))

- Ask participants to provide examples of protective factors.
  Examples of Protective factors may include: a good network of community resources such as church, other community resources that help families in crisis including early intervention programs focused on family-centered services, a warm and loving family, circle of friends, sibling support, or easy going temperament.

- Show **Resilience** slide (**Slide 136**) and go over the content;
  Resilience refers to successful coping and adaptation despite adversity
  Three aspects to resilience
    - overcoming the odds (share an example of a child who was diagnosed not to succeed, based on their diagnosis and then went past his/her expectations)
    - sustaining competence under pressure (competence is the ability

to perform a specific task, action or function successfully even under pressure or under uncomfortable or undesirable conditions – an example would be to do well on a test well even though you have a bad cold)
- recovering from trauma (share an example of someone learning that their new born was born with a heart problem and feels depressed and traumatized then recovers to discuss the options)

- Remind participants of the quiz on resiliency they had taken earlier and seek examples of resilience.

2.3 Small group activity: Risk & Resilience in Young Children

The purpose of this activity is to encourage the DI Assistants to review the information of developmental milestones and identify the risk and resilience factors using six case studies of young children between 6- 36 months of age. (This activity will take approximately 45- 60 minutes from start to finish.)

2.3.1 Steps:

- Divide the participants into 5 groups (or fewer groups if there are less participants; but make sure that there are approximately 3 members per group)

- Distribute the **Case Study** handouts (**H17a-f, pages 87-95**). Give each participant a handout of the case study of children. Each group member must receive the same case study (Charlayne, Nancy, Eden, Stan, William, or Natalie)

- Use **Activity: Risk, Protection, & Resilience** slide (**Slide 137**) to explain to the group the activity and its purpose.

- Ask each group to highlight some of the risk factors for their case study. What are the protective factors and resilience factors they see?

- Ask each group to choose a leader and a note taker

- Ask the group to get back together in 30 minutes.

- After 30 minutes, refer to **Activity: Your Turn** slide (**Slide 138**). Ask the leader of each group to briefly share the :
  a. Case Study
  b. Child's skills in each developmental domain,
  c. Risk factors for the child.
  d. Protective factors
  e. Resiliency factors

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- Allow each group no more than 5-7 minutes to report.
- Summarize. Remind participants that they will be working with these case studies in the same groups again in Module C.
- Inform participants that this ends the section on risk factors that may prohibit or impede typical development and the protective/ resiliency factors that may counteract these risk factors. Let them know that in the next section they will learn about the importance of the relationship between child development and the concepts of developmental delays and disability.

Goal 3: Discuss the importance of the relationship between child development and the concepts of developmental delays and disability

3.1 Discussion: Unique Characteristics of Infant Toddler Services

- Use **Early Intervention: Concepts of Developmental Delays and Disability** handout (**H18, page 96**) **and Unique Characteristics of Infant/Toddler Services: Early Intervention** slide (**Slide 139**).

- Present each of the following point on the slide, seek examples based on the participants' personal and professional experiences with young children that may apply:
  - The correct terminology to use in early intervention for children receiving services is birth TO three OR children birth THROUGH two.
  - Delay or disability is difficult to diagnose at young age – and thus "developmental delay" and "established condition" are used as the two categories for determining eligibility for the system of early intervention. Some developmental lags may naturally or spontaneously disappear by school age. For example, some children say first words by 18 months and others do not say their first words before until just before 3 years of age. Even physical problems may not be evident before 6 months until primitive reflexes integrate.
  - Primitive (infant) reflexes are repetitive, automatic movements that are essential for development of head control, muscle tone, sensory integration and development. They form the basis of our postural, lifelong reflexes. These primitive reflexes surface in utero and infancy and become inhibited as the movements do their job and movements become more practiced and controlled. When a baby has been given the opportunity to develop freely and naturally the primitive reflexes will integrate and no longer be active. When the primitive reflexes remain active then many difficulties can emerge, for example the "startle" reflex is present in newborns.
  - Primary responsibility for supporting the child's development falls with the family.
  - Parents and caregivers are the primary provider of developmental intervention, with support and guidance from early intervention provider.

- Interventions are best carried out in typical routines of daily life and within the natural environment of the family, referred to as "everyday routines, activities and places". In other words, children learn throughout the day, wherever they are and whatever they do. Draw participants' attention to **A-H10, page 73 Providing Services in the Natural Environment** handout that was used in the previous Module A. Seek examples from them of everyday routines, activities and places.
- Intervention may have to address multitude of domains – requiring multidisciplinary expertise and possibly collaboration among providers from different agencies or fields. . For example, a child w/ cerebral palsy may not learn to sit up, hold a spoon or form first words or put together a simple puzzle without specific accommodations or instruction. This child may also have extensive medical needs which must be considered as part of the plan of early intervention supports and services. Consequently, a team of professionals from different disciplines and even agencies work together with the family to direct intervention and provide support.
- The child's developmental progress is greatly dependent on the parent's ability to provide for and support their child. For example, if the child is a member of a family that is experiencing poverty, it may mean that the child's nutrition is at risk, if a family does not have reliable transportation, it may mean appointments with doctors or specialists are missed. If parents are overwhelmed or exhausted it may increase the likelihood of abuse or neglect. If parents are very protective of their child, they may limit the experiences of the child due to fear of harm.

- Address questions/comments.

3.2 Lecture: When are differences considered delay or disability?

- Use **Early Intervention: Concepts of Developmental Delays and Disability** handout (**H18, page 96**) and **When are differences considered delay or disability?** slide (**Slide 140**) and explain that difference are considered delay or disability:
  - When the "when" or "how" of development is outside of what is considered "typical development."
  - When a child has a diagnosed physical or mental condition that has a high probability of resulting in delays in development.

- Briefly allude to the case studies in the previous activity. Discuss the development of each of the children in different domains and causes for concern.

- Remind the participants that as per the principles of development, no matter when children go through the progression of development they are always on that continuum.

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- Use **Remember…** slide (**Slide 141**) to explain that disability is just another part of who the child is.
  - This slide illustrates the "paradigm shift" in how we think about young children with disabilities. "Deviance" is a word with negative connotations. Children with special needs are more like other children than they are different. Their disability is not what defines them.
  - We need to view differences as merely differences rather than as deviance.
  - When we see deviance, we devalue people.
  - Any difference is only one part of who that child is.

3.3 Summary

- Use **Pyramid of Developmental Influences** handout and slide (**H19, page 97/ Slide 142**) to introduce the Pyramid of Developmental Influences, developed by Stanley Greenspan and colleagues that represents child development and the role of early intervention supports and services.

- Show **Slide 143** and explain that this metaphor is obvious as we look at the levels. The influences of developmentalists such as Erikson and Maslow will also be obvious.

- Erikson describes stages of development through life (Infancy, Early Childhood, Late childhood, School age, Adolescence, Young Adulthood, Adulthood and Maturity). This implies a person continues to develop at all ages. And Abraham Maslow established a ladder for meeting human needs similar to Greenspan.

- Give and seek examples of how each tier can influence development. Example: poor nutrition in the early years has a definite influence on brain development.

- Explain that the level of influence of each tier on child development is hierarchical and arranged in a specific order. According to this model, specific interventions have the least amount of influence on a child's development and will not be successful without consideration of the other areas first. The other four areas have a much greater impact on development.

- This information has great relevance in working with families of children with disabilities. When working with families, it is important to understand where on the pyramid they may be. The assessment of family's priorities needs, and concerns that is required by the law can give us that information. Unless the family's and the child's basic needs are met, it is not possible for the families to concentrate on providing a learning experience to the child.

- Show **Slide 144** and point out that however, typically what we see is that a greater importance is placed on the specific interventions making the pyramid look off-balance. We need to remember that in the context of all these influences, interventions are only one small piece.

- Inform participants that this ends Module B of the first Academy. You will re-group after a short break for the final module, Module C where you will discuss the overview of exceptionality.

- Inform the participants that this ends module B on Overview of Child Development. The next module will provide an overview of exceptionality.

- Address any questions/concerns that the participants might have with regards to Module B or in general.

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Module C:
Overview of Exceptionalities

Note to the instructor: If you are covering this on a different day or after a short break, welcome the participants to the session and revisit the group norms agreed upon at the beginning of Module B.

A. Recap of Module B

- Using **Recap of Module B: Overview of Child Development** slide (**Slide 145);** remind The DI Assistant what they had covered in the previous module.
  - Major motor, cognitive, communication, social/emotional, and adaptive milestones
  - The risk factors that may prohibit or impede typical development and the protective/ resiliency factors that may counteract these risk factors
  - The importance of the relationship between child development and the concepts of developmental delays and disability

- Show **Slide 146-147** and inform the participants that we will now learn about **Module C: Overview of Exceptionalities**, the third and final Module out of a total of 3 modules in this Academy.
  1. Demonstrate an understanding of state and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA and the Early Intervention system
  2. Recognize the motor, communication, cognitive, social/emotional, and adaptive needs that infants/toddlers may have as a result of a developmental delay.
  3. Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.

Goal 1: Demonstrate an understanding of state and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA and the Early Intervention system

1.1 Lecture: Eligibility Determination

- Show **Slide 148** and inform the participants that we are going to review state and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA**.**

- Before beginning with eligibility definitions, using and **Steps: From Referral to Exit for Part C** handout **(H20, page 98/ Slide 149)**, briefly go over the steps that are followed from the point of referral until the child exits out of the Part C program. Inform participants that this is only an overview of the assessment and evaluation process. This topic will be covered in depth in the **Academy II: Fundamentals of the IFSP Process**.

- Explain that after identification, followed by referral, a multi disciplinary team that includes professionals from diverse fields (e.g. special educator, speech language pathologist, occupational therapist, etc.) come together to conduct a comprehensive assessment and evaluation. The multi disciplinary team members are trained to utilize appropriate methods and procedures and the team determines the eligibility for services for a child and family based on the consideration of all information gathered during the assessment process and using informed clinical opinion rather than a single standardized test score.

- Reemphasize that for now we will address the key concept of Eligibility Deter-

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mination while all other steps and key concepts of Assessment and Evaluation, Multidisciplinary Evaluation and Informed Clinical Opinion will be covered in depth in **Academy II: Fundamentals of IFSP Process.**

- Use **Early Intervention Eligibility Determination** handout and slide (**H21, page 99/Slides 150**).

- Inform the participants that eligibility for early intervention is determined by each state's definition of developmental delay and includes children with established physical or mental conditions with a high probability of resulting in developmental delay. However, states may choose to include children at risk for disabilities in the group eligible to receive early intervention services. The only groups of children who fall into the "at risk" category that Colorado serves are those who have a parent or parents who meet the criteria of having a developmental disability. This group of children is served using only state early intervention dollars and not federal funding.

- Colorado does not currently serve this group of children.

- Show **Eligibility Determination in Colorado** slide (**Slide 151**) and explain, in Colorado, Community Center Boards are responsible for ensuring a local system of child find that includes public awareness, identification and referral, eligibility determination, and evaluation.

- Inform the participants that there are two ways to determine eligibility for the Early Intervention System**.**

- Show **Category # 1: Eligibility Determination in Colorado** slide (**Slide 152**) on the first eligibility determination category:
  Category #1: Children who have a Delay in Development: having a significant delay in development in one or more of the following domains:
  - thinking and learning skills (cognitive development)
  - moving, seeing, and hearing (physical development)
  - understanding and using sounds, gestures, and words (communication development)
  - responding to and developing relationships with other people (social-emotional development)
  - taking care of one's self when doing things like feeding or dressing (adaptive development)

- Show C**olorado's Definition of Developmental Delay** slide **(Slide 153)***:*
  Colorado's Definition of Developmental Delay In Colorado the rigorous definition of a "developmental delay" means an infant or toddler who has a 25% or greater delay in one or more areas of development when compared with chronological age or the equivalent of 1.5 standard deviations or more below the mean in one or more areas of development.

- Explain that we know there is a wide range of typical development that ranges from what professionals would consider a "little early" or a "little late". Example – most babies begin walking around 12 months. However, some babies can begin as early as 9 months or as late as 16 months. These are still within the "typical" range of development. The level of delay is determined through consideration of all assessment information that has been gathered, using informed clinical opinion. Play-based and family assessments, observation, and standardized testing are all methods that might be used to inform the eligibility determination

- Show **Category # 2: Eligibility Determination in Colorado slide (Slide 154)** about the second eligibility determination category:
Category #2: Children with an Established Condition: having a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development.

- Show **Conditions That May Be Associated with Delays in Development** slide **(Slide 155)** to explain what conditions that fall into the second category: Explain that Colorado has an interactive database of established conditions, which can be found on the eicolorado.org website. You can type in the name of a condition and if it is an established condition under which a child is eligible, it will show up as such in the database.
  - Low birth weight infants weighing less than 1,200 grams
  - Postnatal (after birth) acquired problems resulting in delays in development, including but not limited to severe attachment disorder
  - Chromosomal syndromes and conditions (e.g. Down syndrome)
  - Congenital syndromes and conditions
  - Sensory impairments (some hearing and visual impairments)
  - Metabolic disorders
  - Prenatal or perinatal infections resulting in significant medical problems and health issues

- Inform the participants that the second eligibility determination category is often referred to as "categorical eligibility." The key issue here is: does the condition have a *high probability* of resulting in a delay?

- Using **Categories of Disability under IDEA** slide (**Slide 156),** inform the participants that the disability categories and the criteria for eligibility change when children move from Early Intervention (Part C) to preschool special education (Part B) when they turn three years old. There are 13 disability categories for Part B. Inform the participants that they will learn more about the disability categories under Part B in the **Academy IX on Transition**.

- Refer the participants to the N*ational Dissemination Center for Children with Disabilities* website if they are interested in learning more about Categories of disability for Part B:
http://www.nichcy.org/InformationResources/Documents/NICHCY%20PUBS/gr3.pdf

- Check for understanding by asking questions and request for any clarifying questions.

Goal 2: Recognize the motor, communication, cognitive, social/emotional, and adaptive needs that infants/toddlers may have as a result of a developmental delay.

2.1 Activity: Recognizing Identifying-Development Delays in Young Children

The purpose of this activity is to introduce developmental delays in young children through the use of case stories.

2.1.1 Steps:

- Explain the purpose of the activity and emphasize that it is not the DI Assistants' role to identify delays/disabilities in infants and toddlers. Their role is to provide services, under the guidance of their supervisor, that are outlined in the IFSP based on the concerns and priorities of the families, not the diagnosis of the child.
- Remind participants of the common developmental conditions in young children resulting from biological and environmental risk factors.
- Show **Activity** slide (**Slide 157**) and give directions for the activity.
- Divide the participants into the same 6 groups used for the Case Stories in Module B (or less groups if there are less participants; but make sure that there are approximately 3 members per group)
- Ask each participant to use the same handout of the **Case Stories** (**H17a-f**, **pages 87-95**) of the child they had received in Module B. Each Group members must receive the same case story (Charlayne, Nancy, Eden, Stan, William, or Natalie).
- Ask the participants to also open their handouts **Developmental Milestones** (**H14a-e**, **pages 77-81**) and use it as a reference for this activity.
- Ask each group to review the case-study again and identify and list observation(s) about the child's development delays on each of the following five domains: motor, communication, cognitive, social/emotional, and adaptive
- Encourage participants to refer to the information they noted when they had identified risk and resiliency factors in the previous section.
- Ask each group to list the family's concerns and number their list based on the family's priorities.
- Share with the large group

Goal 3: Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.

3.1 Discussion: The Power of Language

- Show the **The Power of Language** slide (**Slide 158**) and ask the participants to provide examples of words and phrases associated with disabilities and individuals with disabilities – negative, positive, or condescending. Examples that may come up are:
  - Mentally retarded or retard
  - SPED (Special Education) kid
  - I work with CP (Cerebral Palsy) kids
  - That is the MR (Mentally Retarded) room
  - Child can't really do anything
  - Poor kid

- Ask the group:
  - How do you feel when you hear these words?
  - How would a person with a disability feel?
  - How would a parent or a loved one of a child with disability feel?
  - Why are we concerned about the words and names people use?
  - How are words connected to feelings?

- Ask the group:
  - How are some of the ways that families of children with disabilities are treated negatively when communicating with them?

- Use, **Guidelines for Speaking about Families** slide (**Slide 159**) to emphasize your point.: Families should be described in the same respectful manner, whether or not they are present
  - In the case of a written report, keep in mind parents have the right to examine records related to their children
  - Become aware of and avoid language that families might find offensive
  - Use people first language at all times

- Show **People First Language** slide (**Slide 160)** and highlight that the participants must use people first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.

- Remind participants to try not to use words or phrases that are judgmental when describing families.

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3.2 Discussion: What is People first language?

- Distribute the **"People First Language" by Kathy Snow** handout and slide (**H22, page 100 / Slide 161**). (the article can be downloaded from the following website: http://sda.doe.louisiana.gov/Lists/Resources/Attachments/11/PFL8.pdf
- Give participants a few minutes to review the article. Request for reflection or feedback from participants on the following questions;
  - What is people first language?
  - Why is it important to use people first language?
- Acknowledge responses and sum up the discussion by reading **What is People First Language**? slides (**Slides 162-163**):
  - People First Language (PFL) represents more respectful, accurate ways of communicating. People with disabilities are not their diagnoses or disabilities; they are people, first.
  - PFL is not about "political correctness," it's about good manners and "the golden rule."
  - People First Language recognizes that individuals with disabilities are – first and foremost – people. It emphasizes each person's value, individuality, dignity and capabilities.
- Remind participants that the correct use of language is available in the last part of **"People First Language" by Kathy Snow** handout **(H22, page 100).**
- Point out that we are going to look at some more examples to provide further guidance on what terms to use and which ones are inappropriate when talking or writing about people with disabilities.
- Use **Slides 164-166** and **Use of People First Language Vs Labels** handout **(H23, page 101)** review some of the stereotypical terms used for people with disabilities and the alternate terms to use.

People First Language to Use	Instead of Labels that Stereotype and Devalue
• **people/individuals** with disabilities **an adult who has a disability** **a child with a disability** **a person**	• the handicapped the disabled
• **people/individuals** without disabilities **typical kids**	• normal people/healthy individuals atypical kids
• **people with** intellectual and developmental disabilities **he/she has a cognitive impairment** **a person who has Down syndrome**	• the mentally retarded; retarded people he/she is retarded; the retarded he/she's a Downs kid; a Mongoloid; a Mongol
• **a person who has** autism	• autistic
• **a person who has a learning disability**	• he/she is learning disabled
• **a person who is deaf** **he/she has a hearing impairment/loss** **a man/woman who is hard of hearing**	• the deaf
• **person who is deaf and cannot speak** **who has a speech disorder** **uses a communication device** **uses synthetic speech**	• is deaf and dumb mute
• **a person who is blind** **a person who has a visual impairment** **man/woman who has low vision**	• the blind
• **a person who has a learning disability**	• he/she is learning disabled
• **a person who has epilepsy** • **people with a seizure disorder**	• an epileptic a victim of epilepsy
• **a person who** uses a wheelchair **people who have a mobility impairment** • **a person who walks with crutches**	• a person who is wheelchair bound • a person who is confined to a wheelchair • a cripple
• **a person who has** quadriplegia • **people with paraplegia**	• a quadriplegic • the paraplegic
• accessible **buses, bathrooms, etc.** **reserved parking for people with disabilities**	• handicapped buses, bathrooms, hotel rooms, etc. handicapped parking
• **he/she is of small or short stature**	• a dwarf or midget

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- Summarize the discussion as follows:
  - As professionals, we help shape the views others have of families. Very often, we use shorthand, jargon, and labels without realizing the effect on families and on the perceptions others develop about them.
  - As professionals, we must consider Kathy Snow's point about "special needs". She says that stating a child has "special needs" already makes it seem as if their needs are so different that they need a specialized setting which cuts them off from typical life experiences. Kathy Snow also emphasizes that all children have "individual" needs.
  - We need to incorporate the guidelines we generated today for speaking about families into the way we discuss families in meetings, and talk with families themselves.
  - We need to model respectful communication.
  - The use of people-first language is not a superficial issue, and must not be dismissed merely as a matter of "political correctness" – it's a matter of respect
  - The words that we use to describe individuals with disabilities are powerful and they send strong messages.
  - Using respectful, accurate language supports the self-esteem of individuals and helps to eliminate the prejudice of others.
  - Those who support individuals with disabilities must be diligent in modeling the use of people-first language
  - When we talk about individuals with disabilities, we almost always link the disability with the individual "Holly, who has CP" is coming to playgroup" It's important to challenge people to think about whether or not that information is even needed. In this case, isn't it simply enough to say "Holly is coming to playgroup today?"

3.3 Discussion: Resources

- Use **Resources** handout and slides (**H24, page 102 /Slides 167- 172)** and briefly go over the list of resources through the websites.
- Let participants know that their final assignment for the class is based on this handout.
- Address questions/comments as you go along.

Law and Policy:

1. http://www.disabilityresources.org/ABC.html: This website provides a quick guide to some of the more common acronyms in disability education, law, medicine and rehabilitation.
2. http://idea.ed.gov/explore/home: This is the U.S. Department of Education, Office of Special Education Programs' (OSEP's) website on IDEA.

Parent Groups

3. http: //www.peakparent.org/ :PEAK Parent Center is Colorado's federally designated Parent Training and Information Center (PTI). PEAK assists families and others through services like its telephone hotline, workshops, conferences, website, and publications.

4. http://www.pacer.org/index.asp. The PACER Center (Parent Advocacy Coalition for Educational Rights) helps to expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents.

Specific Disabilities

5. http://www.thearc.org/ The Arc is the world's largest community based organization of and for people with intellectual and developmental disabilities.
6. http://www.ucp.org/: United Cerebral Palsy (UCP) is the leading source of information on cerebral palsy and is a pivotal advocate for the rights of persons with any disability.
7. http://www.ndss.org/ The National Down Syndrome Society is the national advocate for the value, acceptance and inclusion of people with Down syndrome.
8. http://www.nationalautismassociation.org/index.php The National Autism Association educates and empowers families affected by autism and other neurological disorders.

Early Intervention

9. http://www.zerotothree.org/ 0-3 is a national nonprofit organization that informs trains and supports professionals, policymakers and parents in their efforts to improve the lives of infants and toddlers.
10. http://www.nichcy.org/ National Dissemination Center for children with Disabilities (NICHCY) is a central source of information on: disabilities in infants, toddlers, children, and youth; IDEA; No Child Left Behind (as it relates to children with disabilities); and research-based information on effective educational practices.
11. http://www.dec-sped.org/ The Division for Early Childhood (DEC) is one of seventeen divisions of the Council for Exceptional Children (CEC) – the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. DEC is especially for individuals who work with or on behalf of children with special needs, birth through age eight, and their families.

3.4. Assignment: Further Research

- Show **Homework Assignment** handout and slide (**H25, page 103/Slide 173**) and refer to **Resources** handout (**H24, page 102**).

- Divide the class into pairs.

- Have each pair to pick a website from the list (or obtained through their own) that they would like to research.

- DI Assistants will review the website based on the following criteria:
  - What is the information provided on this website?
  - What age range of children does the website cover?

  - Who does the website primarily cater to- service providers, policy makers, researchers, or families?
  - How will this website help them in their work with children and families?

- Explain to the DI Assistants that they will be expected to meet outside of class-time to do this research.

- Ask them to use the provided URL's to research their choice. They may also use libraries or sources of written information.

- Make sure that no more than one pair is researching each website.

- Give deadline for submission as well as mode of delivery of the assignment to you.

- Check for understanding and request for any clarifying questions before going on to the next section.

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Orientation to Early Intervention Academy Handouts

Module Goals

Module A: History, Legal Precedents, and Values of Early Intervention Services

The DI Assistant will:

1. Demonstrate understanding of the history of the IDEA.
2. Discuss the purpose, required components and rules and regulations for Part C.
3. Describe the organizational structure that enables the implementation of Part C of IDEA in Colorado.
4. Discuss the core values and concepts that guide early intervention services under Part C of IDEA

Module B: Overview of Child Development

The DI Assistant will:

1. Identify major motor, communication, cognitive, social/emotional, and adaptive milestones
2. Recognize the risk factors that may prohibit or impede typical development and the protective/ resiliency factors that may counteract these risk factors
3. Discuss the importance of the relationship between child development and the concepts of developmental delays and disability.

Module C: Overview of Exceptionalities

The DI Assistant will:

1. Demonstrate an understanding of state and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA and the Early Intervention system
2. Recognize the motor, communication, cognitive, social/emotional, and adaptive needs that infants/toddlers may have as a result of a developmental delay.
3. Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.

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Alphabet Soup/ Glossary

What is Early Intervention?

Broadly speaking, early intervention services are specialized health, educational, and therapeutic services designed to meet the needs of infants and toddlers, from birth through age two, who have a *developmental delay* or disability, and their families. At the discretion of each State, services can also be provided to children who are considered to be *at-risk* of developing substantial delays if services are not provided.

Sometimes it is known from the moment a child is born that early intervention services will be essential in helping the child grow and develop. Often this is so for children who are diagnosed at birth with a specific condition or who experience significant prematurity, very low birth weight, illness, or surgery soon after being born. Even before heading home from the hospital, this child's parents may be given a referral to their local early intervention office.
Some children have a relatively routine entry into the world, but may develop more slowly than others, experience set backs, or develop in ways that seem very different from other children. For these children, a visit with a developmental pediatrician and a thorough evaluation may lead to an early intervention referral, as well. However a child comes to be referred assessed, and determined eligible – early intervention services provide vital support so that children with developmental needs can thrive and grow.

Thus, early intervention provides developmental supports and services to children birth through two years of age who have special developmental needs and their families. It can help improve child's ability to develop and learn. It can also help the family learn ways to support and promote child's development, within the family activities and community life.

In Colorado, the overall system of early intervention is known as **Early Intervention Colorado**. It is designed to "connect" a family with needed **early intervention supports and services** to help their infant or toddler grow and develop, and to help their family in this process through the implementation of an Individualized Family Service Plan (IFSP) based on the concerns and priorities of the family. It is a voluntary program and does not discriminate based on race, culture, religion, income level, or disability.

(From: The National Dissemination Center for Children with Disabilities *and* Early Intervention Colorado)

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Pre/ Post Quiz: Module A

Check the correct response.

Q1. What does IDEA stand for?

- *Individuals with Disabilities Environment Act*
- *Individuals with Disabilities Equality Association*
- *Individuals with Disabilities Education Act*
- *Illicit Drugs Enforcement Agency*

Q2. When did the last authorization of IDEA take place?

- *1950*
- *1975*
- *2000*
- *2004*

Q3. Which part of the IDEA covers Early Intervention services for infants and toddlers and their families?

- *Part A*
- *Part B*
- *Part C*
- *Part D*

Q4. The federal government requires that the governor must designate a lead agency to receive the grant and administer the program to provide early intervention services for infants and toddlers with disabilities and their families. Which state agency has been designated "lead agency" in the state of Colorado?

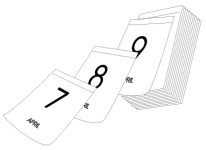
- *Colorado Department of Education*
- *Colorado Department of Human Services/ Division for Developmental Disabilities*
- *Colorado Department of Public Safety*
- *Colorado Department of Law*

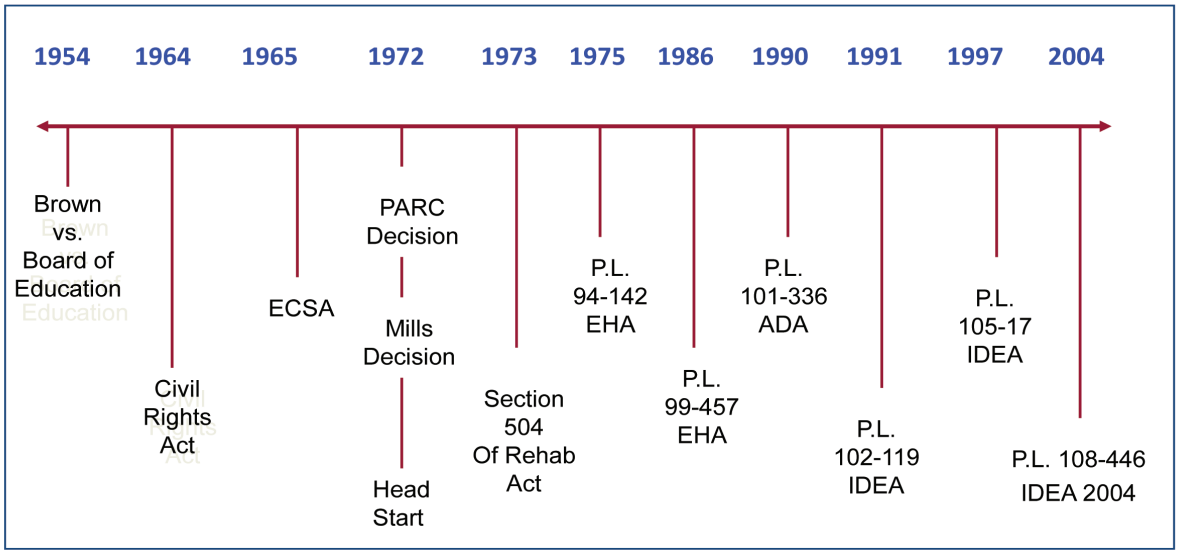
Q5. What is the purpose of the Colorado Interagency Coordinating Council (CICC)?

- *To provide funds to the state to support the services for infants and toddlers*
- *To train professionals*
- *To provide services to families of infants and toddlers with disabilities*
- *To advise the lead agency for infant toddler services in Colorado on how to implement the services.*

History of Public Policy

History of Public Policy
1954-2004





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Different Parts of Individuals with Disabilities Education Act (IDEA)

IDEA Part A:

- Gives general information about the law, why the law was enacted and who it serves.
- Gives definitions for terms referenced in the law.
- Defines what the state and federal government needs to do administratively

IDEA Part B:

- Part B is the section of the law that requires states to conduct child find activities for children birth to 21 years.
- Part B serves students through the semester in which they turn 21 or when they graduate with a regular diploma.
- Highlight that the work of the DI Assistant falls under Part C

IDEA Part D

IDEA Part D authorizes discretionary funding for a variety of activities:

- Research and Innovation
- Personnel Preparation
- Technical assistance
- Dissemination of information

IDEA Part C

IDEA Part C provides financial assistance for states to:

- Maintain and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families.
- Facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources.
- Enhance their capacity to provide quality early intervention services and expand and improve existing early intervention services.
- Enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations.
  - A primary theme of Part C and IDEA is access, particularly for populations of children who historically have not had easy or ready access to the services that they need. This purpose statement is reflected in the law through the concept of equitable distribution of resources.

In general, the intent of Part C was not to create a new program, but to provide the "glue" with which to pull existing early intervention programs and services together.

Required Components of Part C of IDEA (Early Intervention)

- Statewide Public Awareness
  - ✓ Created through brochures, videos, toll-free numbers

- Child Identification
  - ✓ School district Child Find or local interagency teams

- Central Directory of Resources
  - ✓ Early Intervention Colorado (eicolorado.org) and local web sites

- Data Collection
  # of children & how they are served

- Personnel Development/ Standards
  - ✓ Includes Preservice and inservice training
  - ✓ The purpose of Personnel Development is to ensure qualified personnel are supporting children and families
  - ✓ Another dimension of Personnel Development is having policies and procedures to insure that the highest qualified staff provides services and supports through methods that are research-based and best practice.

- Evaluation and Monitoring
  Includes Onsite monitoring, desk audit, and focused monitoring
  - ✓ Onsite monitoring: Community visit where files are reviewed – findings are shared at exit interview and by report
  - ✓ Desk Audit: Data is reviewed to determine level of compliance with federal indicators
  - ✓ Focused monitoring: Based on desk audit review, involves staff and administrator interviews and file reviews

- Equitable Distribution of Resources
  - ✓ In Colorado, funds are distributed to 20 regional community center boards (CCB).

- Child and Family Entitlements
  - ✓ Multidisciplinary Evaluation & Assessment
  - ✓ Individualized Family Services Plan (IFSP)
  - ✓ Service Coordination
  - ✓ Provision of Services in Natural Environments
  - ✓ Procedural Safeguards (Family Rights)

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Who Is Responsible for Part C of IDEA in Colorado?

For Part C of IDEA, the Governor of each state designates the lead agency.

In Colorado:

- The Colorado Department of Human Services (CDHS), Division for Developmental Disabilities (DDD) is the lead agency for Part C in Colorado, and the program is referred to as Early Intervention Colorado. The IDEA Part C funds come to CDHS, DDD.

- Colorado Interagency Coordinating Council (CICC) acts as the advisory body to the DDD. The CICC consists of appointed representatives of a variety of statewide stakeholders – parents, providers, representatives of other state agencies involved in early intervention services and other entities

- DDD contracts with twenty Community Centered Boards (CCBs) to deliver community-based services to children with eligible for early intervention. These CCBs, located in rural plains, mountain communities, and cities along urban corridor, are private non-profit organizations designated by the state as the single entry point into the long-term service and support system for persons with developmental disabilities. DDD disperses the early intervention funds to local Community Centered Boards

- DDD requires that each CCB have a Local Interagency Coordinating Council (LICC) that provides the interagency collaboration necessary to effectively implement early intervention services. The CCBs provide service coordination and direct early intervention services to eligible children and their families through their early intervention staff (including DI Assistants) or contract independent providers or use a combination of own staff and contract providers.

Colorado Interagency Coordinating Council (CICC) Guiding Values

CICC Vision: "*The Colorado Interagency Coordinating Council will support a wide range of activities that promote inclusive communities, that enhance participation and the growth, development, and quality of life for children birth to three and their families in a culturally competent manner.*"

Guiding Values for EI Supports & Services	What Does It Look Like? (Key words)
1. Children and families are valued for their unique capacities, experiences, and potential.	
2. Families have the right and responsibility to make decisions on behalf of their children and themselves	
3. Parent leadership is valued as an essential aspect of the statewide system of early intervention.	
4. Communities are enhanced by recognizing and honoring the diversity among all people.	
5. Families make the best choices when they have comprehensive information about the full range of formal and natural resources in their communities.	
6. Creative, flexible, and collaborative approaches to services allow for individual child, family, and community differences.	

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Providing services in the Natural Environment

What is a natural environment?
Natural environments are places, including the home, and community settings, in which children without disabilities typically participate, live, learn, and play.

Examples of **Natural Environments**
- home
- gymnastic programs
- parks
- neighbor's homes
- neighborhood play groups
- toy lending libraries
- museums
- church festivals
- swimming pools
- family hikes
- mommy and me class
- child care
- birthdays
- fast food restaurants (and play spaces)
- book stores and library story hours

Daily Routines in Natural Environments
- brushing teeth
- diapering
- meal time
- playing with siblings
- playing with neighbors
- watching TV
- folding laundry
- reading stories
- nap time

What is Home Visiting?
- Home visiting is a "process by which a professional or paraprofessional provides help and information to a family in their own home."
- Home visiting can take different forms – it can be the only mode of providing services or it can be a part of any array of services or it can be primarily provide transportation when needed.

Prerequisites for Home Visitors
- ✓ Flexibility
- ✓ Respect for differences
- ✓ Sensitivity to all family members
- ✓ Self- observation of one's own mental and emotional state
- ✓ Sense of Humor
- ✓ Ability to "accentuate the positive"
- ✓ Good observational Skills
- ✓ Skilled in interacting with children

Transdisciplinary Team/Primary Service Provider Model

Please order/ download the "**Transdisciplinary Team/Primary Service Provider Model"** brochure.

The brochure can be downloaded at http://www.eicolorado.org/Files/Transdisciplinary_PSPBrochure_FINAL.pdf?CFID=7923341&CFTOKEN=83131318.

It can be ordered at Early Intervention Colorado by visiting their website: www.eicolorado.org or calling 1-888-777-4041

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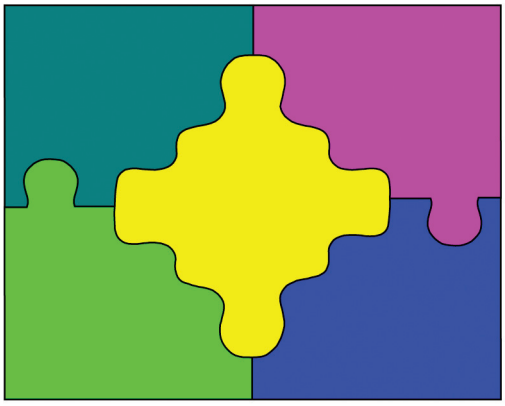
The Various "Parts"

Development is influenced by:

- Family context and relationships
- Culture
- Genetics, biochemistry, physiology
- Socio-economic context
- Environment and experiences
- Five developmental domains



Developmental Domains

- Motor development : Includes Motor (fine/gross motor) and Sensory systems (such as vision and hearing)
- Communication development (gestures, speech and language)
- Cognitive development (playing, thinking, exploring)
- Social/Emotional development (relating to others)
- Adaptive or self-help (eating, dressing, toileting)

These five domains of development reflect the standard manner of dividing the study of child development and are reflected specifically on the Colorado IFSP in this order

Principles of Development

Principles	Your comments/ notes
Principle 1 Development is sequential and occurs in bursts and plateaus.	
Principle 2 Development is Interdependent: Progress in one developmental domain influences progress in other domains.	
Principle 3 Children's growth and development are influenced by both their genetic constitution and environmental experiences; and there is interplay between the two.	
Principle 4 Development occurs differently for different children.	

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Important Milestones: By the End of Three Months

Babies develop at their own pace, so it's impossible to tell exactly when your child will learn a given skill. The developmental milestones listed below will give you a general idea of the changes you can expect, but don't be alarmed if your own baby's development takes a slightly different course.

Social and Emotional
- Begins to develop a social smile
- Enjoys playing with other people and may cry when playing stops
- Becomes more expressive and communicates more with face and body
- Imitates some movements and facial expressions

Movement
- Raises head and chest when lying on stomach
- Supports upper body with arms when lying on stomach
- Stretches legs out and kicks when lying on stomach or back
- Opens and shuts hands
- Pushes down on legs when feet are placed on a firm surface
- Brings hand to mouth
- Takes swipes at dangling objects with hands
- Grasps and shakes hand toys

Vision
- Watches faces intently
- Follows moving objects
- Recognizes familiar objects and people at a distance
- Starts using hands and eyes in coordination

Hearing and Speech
- Smiles at the sound of your voice
- Begins to babble
- Begins to imitate some sounds
- Turns head toward direction of sound

Developmental Health Watch
- Does not seem to respond to loud noises
- Does not notice hands by 2 months
- Does not follow moving objects with eyes by 2 to 3 months
- Does not grasp and hold objects by 3 months
- Does not smile at people by 3 months
- Cannot support head well by 3 months
- Does not reach for and grasp toys by 3 to 4 months
- Does not babble by 3 to 4 months
- Does not bring objects to mouth by 4 months
- Begins babbling, but does not try to imitate any of your sounds by 4 months
- Does not push down with legs when feet are placed on a firm surface by 4 months
- Has trouble moving one or both eyes in all directions
- Crosses eyes most of the time (occasional crossing of the eyes is normal in these first months)
- Does not pay attention to new faces, or seems very frightened by new faces or surroundings
- Experiences a dramatic loss of skills he or she once had

Source: Centers for Disease Control and Prevention http://www.cdc.gov/ncbddd/actearly/milestones/

Early Intervention Colorado
for Infants, Toddlers & Families

Important Milestones: By the End of Seven Months

Babies develop at their own pace, so it's impossible to tell exactly when your child will learn a given skill. The developmental milestones listed below will give you a general idea of the changes you can expect, but don't be alarmed if your own baby's development takes a slightly different course.

Social and Emotional
- Enjoys social play
- Interested in mirror images
- Responds to other people's expressions of emotion and appears joyful often

Cognitive
- Finds partially hidden object
- Explores with hands and mouth
- Struggles to get objects that are out of reach

Language
- Responds to own name
- Begins to respond to "no"
- Can tell emotions by tone of voice
- Responds to sound by making sounds
- Uses voice to express joy and displeasure
- Babbles chains of sounds

Movement
- Rolls both ways (front to back, back to front)
- Sits with, and then without, support on hands
- Supports whole weight on legs
- Reaches with one hand
- Transfers object from hand to hand
- Uses hand to rake objects

Vision
- Develops full color vision
- Distance vision matures
- Ability to track moving objects improves

Developmental Health Watch
- Seems very stiff, with tight muscles
- Seems very floppy, like a rag doll
- Head still flops back when body is pulled to a sitting position
- Reaches with one hand only
- Refuses to cuddle
- Shows no affection for the person who cares for him or her
- Doesn't seem to enjoy being around people
- One or both eyes consistently turn in or out
- Persistent tearing, eye drainage, or sensitivity to light
- Does not respond to sounds around him or her
- Has difficulty getting objects to mouth
- Does not turn head to locate sounds by 4 months
- Does not roll over in either direction (front to back or back to front) by 5 months
- Seems impossible to comfort at night after 5 months
- Does not smile on his or her own by 5 months
- Cannot sit with help by 6 months
- Does not laugh or make squealing sounds by 6 months
- Does not actively reach for objects by 6 to 7 months
- Does not follow objects with both eyes at near (1 foot) and far (6 feet) ranges by 7 months
- Does not bear weight on legs by 7 months
- Does not try to attract attention through actions by 7 months
- Does not babble by 8 months
- Shows no interest in games of peek-a-boo by 8 months
- Experiences a dramatic loss of skills he or she once had

Source: Centers for Disease Control and Prevention http://www.cdc.gov/ncbddd/actearly/milestones/

The PARA Center

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Important Milestones: By the End of One Year (12 Months)

Babies develop at their own pace, so it's impossible to tell exactly when your child will learn a given skill. The developmental milestones listed below will give you a general idea of the changes you can expect, but don't be alarmed if your own baby's development takes a slightly different course.

Social and Emotional

- Shy or anxious with strangers
- Cries when mother or father leaves
- Enjoys imitating people in his play
- Shows specific preferences for certain people and toys
- Tests parental responses to his actions during feedings
- Tests parental responses to his behavior
- May be fearful in some situations
- Prefers mother and/or regular caregiver over all others
- Repeats sounds or gestures for attention
- Finger-feeds himself
- Extends arm or leg to help when being dressed

Cognitive

- Explores objects in many different ways (shaking, banging, throwing, dropping)
- Finds hidden objects easily
- Looks at correct picture when the image is named
- Imitates gestures
- Begins to use objects correctly (drinking from cup, brushing hair, dialing phone, listening to receiver)

Developmental Health Watch

- Does not crawl
- Drags one side of body while crawling (for over one month)
- Cannot stand when supported

Language

- Pays increasing attention to speech
- Responds to simple verbal requests
- Responds to "no"
- Uses simple gestures, such as shaking head for "no"
- Babbles with inflection (changes in tone)
- Says "dada" and "mama"
- Uses exclamations, such as "Oh-oh!"
- Tries to imitate words

Movement

- Reaches sitting position without assistance
- Crawls forward on belly
- Assumes hands-and-knees position
- Creeps on hands and knees
- Gets from sitting to crawling or prone (lying on stomach) position
- Pulls self up to stand
- Walks holding on to furniture
- Stands momentarily without support
- May walk two or three steps without support

Hand and Finger Skills

- Uses pincer grasp
- Bangs two objects together
- Puts objects into container
- Takes objects out of container
- Lets objects go voluntarily
- Pokes with index finger
- Tries to imitate scribbling

Source: Centers for Disease Control and Prevention http://www.cdc.gov/ncbddd/actearly/milestones/

Early Intervention Colorado
for Infants, Toddlers & Families

Important Milestones: By the End of Two Years (24 Months)

Children develop at their own pace, so it's impossible to tell exactly when yours will learn a given skill. The developmental milestones below will give you a general idea of the changes you can expect as your child gets older, but don't be alarmed if your child takes a slightly different course

Social and Emotional
- Imitates behavior of others, especially adults and older children
- More aware of herself as separate from others
- More excited about company of other children

Emotional
- Demonstrates increasing independence
- Begins to show defiant behavior
- Separation anxiety increases toward midyear then fades

Cognitive
- Finds objects even when hidden under two or three covers
- Begins to sort by shapes and colors
- Begins make-believe play

Language Points to object or picture when it's named for him
- Recognizes names of familiar people, objects, and
- body parts
- Says several single words (by 15 to 18 months)
- Uses simple phrases (by 18 to 24 months)
- Uses 2- to 4-word sentences
- Follows simple instructions
- Repeats words overheard in conversation

Movement
- Walks alone
- Pulls toys behind her while walking
- Carries large toy or several toys while walking
- Begins to run
- Stands on tiptoe
- Kicks a ball
- Climbs onto and down from furniture unassisted
- Walks up and down stairs holding on to support

Hand and Finger Skills
- Scribbles on his or her own
- Turns over container to pour out contents
- Builds tower of four blocks or more
- Might use one hand more often than the other

Developmental Health Watch
- Cannot walk by 18 months
- Fails to develop a mature heel-toe walking pattern after several months of walking, or walks only on his toes
- Does not speak at least 15 words
- Does not use two-word sentences by age 2
- By 15 months, does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- Does not imitate actions or words by the end of this period
- Does not follow simple instructions by age 2
- Cannot push a wheeled toy by age 2
- Experiences a dramatic loss of skills he or she once had

Source: Centers for Disease Control and Prevention http://www.cdc.gov/ncbddd/actearly/milestones/

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Important Milestones: By the End of Three Years (36 Months)

Children develop at their own pace, so it's impossible to tell exactly when yours will learn a given skill. The developmental milestones below will give you a general idea of the changes you can expect as your child gets older, but don't be alarmed if your child takes a slightly different course.

Social and Emotional
- Imitates adults and playmates
- Spontaneously shows affection for familiar playmates
- Can take turns in games
- Understands concept of "mine" and "his/hers"

Emotional
- Expresses affection openly
- Expresses a wide range of emotions
- By 3, separates easily from parents
- Objects to major changes in routine

Cognitive
- Makes mechanical toys work
- Matches an object in her hand or room to a picture in a book
- Plays make-believe with dolls, animals, and people
- Sorts objects by shape and color
- Completes puzzles with three or four pieces
- Understands concept of "two"

Language
- Follows a two- or three-part command
- Recognizes and identifies almost all common objects and pictures
- Understands most sentences
- Understands placement in space ("on," "in," "under")
- Uses 4- to 5-word sentences
- Can say name, age, and sex
- Uses pronouns (I, you, me, we, they) and some plurals (cars, dogs, cats)
- Strangers can understand most of her words

Movement
- Climbs well
- Walks up and down stairs, alternating feet (one foot per stair step)
- Kicks ball
- Runs easily
- Pedals tricycle
- Bends over easily without falling

Hand and Finger Skills
- Makes up-and-down, side-to-side, and circular lines with pencil or crayon
- Turns book pages one at a time
- Builds a tower of more than six blocks
- Holds a pencil in writing position
- Screws and unscrews jar lids, nuts, and bolts
- Turns rotating handles

Developmental Health Watch
- Frequent falling and difficulty with stairs
- Persistent drooling or very unclear speech
- Cannot build a tower of more than four blocks
- Difficulty manipulating small objects
- Cannot copy a circle by age 3
- Cannot communicate in short phrases
- No involvement in "pretend" play
- Does not understand simple instructions
- Little interest in other children
- Extreme difficulty separating from mother or primary caregiver
- Poor eye contact
- Limited interest in toys
- Experiences a dramatic loss of skills he or she once had

Source: Centers for Disease Control and Prevention http://www.cdc.gov/ncbddd/actearly/milestones/

The Resiliency Quiz

by Nan Henderson, M.S.W.

PART ONE:

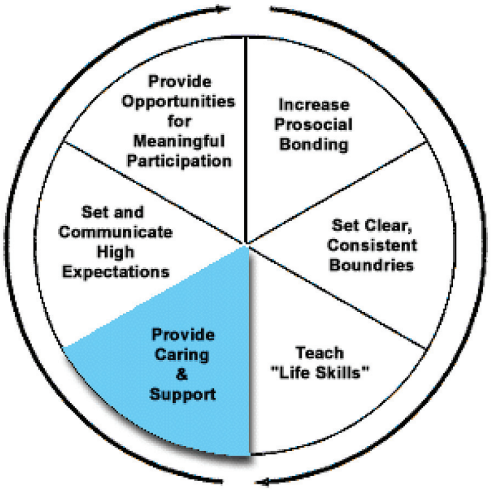
Do you have the conditions in your life that research shows help people to be resilient?

People bounce back from tragedy, trauma, risks, and stress by having the following conditions in their lives. The more times you answer yes (below), the greater the chances you can bounce back from your life's problems "with more power and more smarts."

And doing that is one of the surest ways to increase your self-esteem.

Answer yes or no to the following. Then celebrate your "yes" answers and decide how you can change your "no" answers to "yes."

Figure 1
The Resiliency Wheel



Adapted from the book *Resiliency In Schools: Making It Happen for Students and Educators* by *Nan Henderson* and *Mike Milstein*, *published by Corvin Press, Thoussand Oaks, CA (1996)*

1. Caring and Support

_____ I have several people in my life who give me unconditional love, nonjudgmental listening, and who I know are "there for me."

_____ I am involved in a school, work, faith, or other group where I feel cared for and valued.

_____ I treat myself with kindness and compassion, and take time to nurture myself (including eating right and getting enough sleep and exercise).

2. High Expectations for Success

_____ I have several people in my life who let me know they believe in my ability to succeed.

_____ I get the message "You can succeed," at my work or school.

_____ I believe in myself most of the time, and generally give myself positive messages about my ability to accomplish my goals-even when I encounter difficulties.

3. Opportunities for Meaningful Participation

_____ My voice (opinion) and choice (what I want) is heard and valued in my close personal relationships.

_____ My opinions and ideas are listened to and respected at my work or school.

_____ I provide service through volunteering to help others or a cause in my community, faith organization, or school.

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4. Positive Bonds

_____ I am involved in one or more positive after-work or after-school hobbies or activities

_____ I participate in one or more groups (such as a club, faith community, or sports team) outside of work or school.

_____ I feel "close to" most people at my work or school.

5. Clear and Consistent Boundaries

_____ Most of my relationships with friends and family members have clear, healthy boundaries (which include mutual respect, personal autonomy, and each person in the relationship both giving and receiving).

_____ I experience clear, consistent expectations and rules at my work or in my school.

_____ I set and maintain healthy boundaries for myself by standing up for myself, not letting others take advantage of me, and saying "no" when I need to.

6. Life Skills

_____ I have (and use) good listening, honest communication, and healthy conflict resolution skills.

_____ I have the training and skills I need to do my job well, or all the skills I need to do well in school.

_____ I know how to set a goal and take the steps to achieve it.

PART TWO:

People also successfully overcome life difficulties by drawing upon internal qualities that research have shown are particularly helpful when encountering a crisis, major stressor, or trauma. The following list can be thought of as a "personal resiliency builder" menu. No one has everything on this list. When "the going gets tough" you probably have three or four of these qualities that you use most naturally and most often.

It is helpful to know which are your primary resiliency builders; how have you used them in the past; and how can you use them to overcome the present challenges in your life. You can also decide to add one or two of these to your "resiliency-builder" menu, if you think they would be useful for you.

PERSONAL RESILIENCY BUILDERS
Individual Qualities that Facilitate Resiliency

Put a + by the top three or four resiliency builders you use most often. Ask yourself how you have used these in the past or currently use them. Think of how you can best apply these resiliency builders to current life problems, crisis, or stressors.
(Optional) You can then put a check by one or two resiliency builders you think you should add to your personal repertoire.

- ☐ Relationships – Sociability/ability to be a friend/ability to form positive relationships
- ☐ Humor – Has a good sense of humor
- ☐ Inner Direction – Bases choices/decisions on internal evaluation (internal locus of control)
- ☐ Perceptiveness – Insightful understanding of people and situations
- ☐ Independence – "Adaptive" distancing from unhealthy people and situations/autonomy
- ☐ Positive View of Personal Future – Optimism, expects a positive future
- ☐ Flexibility – Can adjust to change; can bend as necessary to positively cope with situations
- ☐ Love of Learning – Capacity for and connection to learning
- ☐ Self-motivation – Internal initiative and positive motivation from within
- ☐ Competence – Is "good at something"/personal competence
- ☐ Self-Worth – Feelings of self-worth and self-confidence
- ☐ Spirituality – Personal faith in something greater
- ☐ Perseverance – Keeps on despite difficulty; doesn't give up
- ☐ Creativity – Expresses self through artistic endeavor

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You Can Best Help Yourself or Someone Else Be More Resilient by...

1. Communicating the Resiliency Attitude: "What is right with you is more powerful than anything that is wrong with you."

2. Focusing on the person's strengths more than problems and weaknesses, and asking "How can these strengths be used to overcome problems?" One way to do this is to help yourself or another identify and best utilize top personal resiliency builders listed in The Resiliency Quiz Part Two.

3. Providing for yourself or another, the conditions listed in The Resiliency Quiz Part One.

4. Having patience... successfully bouncing back from a significant trauma or crisis takes time.

Nan Henderson, M.S.W., is an international trainer on how to help yourself, your children, or others you care about become more resilient. She speaks to educators, parent and community groups, and to youth on a variety of topics connected to resiliency. She is also the President of Resiliency In Action, Inc., and the author/editor of five books on the topic of fostering resiliency. She can be contacted at nhenderson@resiliency.com

Risk, Resilience, and Protective Factors

- **Risk** may be caused due to:
  - Biological factors -may be genetic or inherited traits from parents- ask participants to give examples of biological factors that they think they inherited from their parents or grandparents?
  - Ecological factors -may be environmental factors that relate to the person and their environment, for example, a person who was born in another country than moved to the USA when they were two or a child born in a poor or in a wealthy neighborhood.
  - Combined biopsychosocial factors draw upon the **biopsychosocial model** (abbreviated "BPS") which is an approach that states that biological, psychological (which entails thoughts, emotions, and behaviors), and social factors, all play a significant role in human functioning in the context of disease or illness. Indeed, health is best understood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms (i.e. factors that may be biological or ecological in nature primarily but may have influence on the other factors as well. (Richman & Fraser, 2003)

  Examples of Risk Factors:
  - *Biological risk factors*: Chronic health conditions, prenatal exposure to toxic substances, disabilities, low birth weight, prematurity, poor health.
  - *Ecological risk factors*: neighborhood violence, parents who are incarcerated, parents who are not literate, parents who work, factors of abuse and/or neglect, the experience of homelessness or poverty, domestic violence, divorce etc.
  - *Combined biopsychosocial factors:* Parental mental illness, parental disability (may be genetic in nature and increase the chances of disability/ mental illness in the child too)

- **Protective factors** :
  - Protective factors are characteristics or conditions that counteract the risk to which children are exposed
  - Protective factors delay, suppress, or neutralize negative outcomes
  - Protective factors sometimes provide a buffer against the risk.
  - Protective factors are important because they provide clues for designing more effective social programs that lessen the risk.
  - Three categories
    - individual factors (e.g. tenacity, optimism, openness) (Parents may have inner strengths or resources that can serve as a foundation and can be utilized to build their resilience including faith, flexibility, humor, communication skills, problem-solving skills, mutually supportive caring relationships)
    - familial factors (e.g. parental support, supervision) (give an example of a family that uses the extended family support or productive alliances with other families and positive family professional partnerships)
    - extra-familial factors (e.g. community networks) (Community services that help families in crisis include early intervention programs that focus on culturally competent, family-centered care)

- **Resilience** refers to successful coping and adaptation despite adversity
  Three aspects to resilience
  - overcoming the odds (share an example of a child who was diagnosed not to succeed, based on their diagnosis and then went past his/her expectations)
  - sustaining competence under pressure (competence is the ability to perform a specific task, action or function successfully even under pressure or under uncomfortable or undesirable conditions – example would be to do well on a test even though you have a bad cold)
  - recovering from trauma (share an example of someone leaning that their new born was born with a heart problem and feels depressed and traumatized then recovers to discuss the options)

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Case Study: William (21 months)

At 21 months William weighs about 25 pounds, which shows good progress from his premature birth weight of 2 pounds 14 ounces. Now he is an active and sociable child with light brown curly hair, brown eyes, and a ready smile. His parents, who are African-American, were not prepared for his birth 2 months early, but when the doctor saw signs that the infant might have a prenatal stroke, they decided to induce the birth. Mom says the doctor "never told me exactly why." Mom and Dad were both upset because they didn't get to hold him after his birth because medical personnel "just took him away." William was in the intensive care unit until he gained two additional pounds, was eating well and gaining weight and had no other health concerns. He did well during his time in the neonatal intensive care unit in the hospital and no complications occurred. Mom and Dad went everyday to the hospital, but it was a traumatic period for them. Although his mother "really wanted to nurse" she was not successful. She feels this is because they gave him bottles in the hospital. For 2 months she used a breast pump and gave him breast milk in the bottle, to get him off to a good start.

William's mother dropped out of college to stay home with him for 3 months because he was so small she didn't feel she could have anyone else stay with him. She says he just slept and ate during that period. Because of his prematurity, doctors had concerns about his vision; and his development has been monitored by a developmental pediatrician. When William's weight reached 6 pounds, his mother went back to college for one term, paying for home care 3 days a week. She found the home care through a friend, and it seemed to work well for about 5 months, but then she got a part-time job working at a mall and needed full time child care. She was able to receive subsidized child care so she could work and finish her college degree...

The first child care program she took him to was near her worksite, and William adjusted well, with no separation problems. She thought the program provided adequate care for William's needs at his age level (9-15 months) at that time. Now that she has graduated and taken a position in her professional field, she has William in a child care program near her home. She takes him before she goes to work, which is an hour's drive away and his dad picks him up when he gets off work, feeds him, and cares for him until she gets home (about 7:00 p.m.). The family is planning to move out of the city to a suburban area closer to their work.

As far as William's development is concerned, his mother says that for a long time she was worried because it seemed "he was never going to do anything." He did smile at 5 months, but it took him "a while even to roll over;" and she thought he crawled a long time (from 11 to 13 months) before walking (at 13 months). "All of a sudden," soon after he started walking, he showed progress in many areas.

Their concerns about his vision are over since there are no signs of problems. In the past few months he has shown the ability to climb stairs on hands and knees, run, "dance," and jump up and down. He plays ball with his dad and enjoys tickling and other roughhousing games. Although he much prefers gross-motor activities, his fine motor skills are progressing. He can fill and dump objects, stack blocks, and press the numbers on his small play phone to make a sound.

William likes to make scribble pictures, and he recognizes the A-B-C song although he does not sing it. His mom says he has now started to do the "imagination thing" such as pretend eating. He imitates words he hears, and routinely says "bye-bye," "hi," and "bah bah" for his bottle and his sippy cup. He also "talks" in strings of sound that aren't understandable. He gets upset when he doesn't get his way and his child care provider has reported that he sometimes hits other kids when they have conflicts over toys.

William has always been good-natured, even when sick, and he enjoys being with the older children of the friend who sometimes cares for him. However, he is independent and thinks he "can do anything" which Mom calls "having an attitude." She says he has always been independent, preferring to sleep in his crib rather than in bed with her (which she preferred), not liking to be rocked, and wanting to walk without holding her hand.

Because of her concerns, Williams' mother called the early intervention system. William was evaluated and found to be eligible for early intervention. There are a number of things that William's mother would like the early intervention providers to help her with. First, she wants them to "go by what my child's needs are". Secondly, she would like them to share some learning activities with her, especially those that will help his speech and literacy to develop. Third, she thinks the early intervention providers "could talk more to me about ideas of things I can do with William. I am a first-time mother and don't always understand how I should be helping him learn and grow." Although they communicate important things, she would like the providers to write down how she can support his learning at home. She feels that William's dad could also benefit from these suggestions because he "doesn't know much about being a dad, since he didn't have a dad around when he was growing up." She hopes the providers will listen to her concerns and suggestions. She is generally pleased at how well William is now developing.

Reference:

Adapted from Bergen, D., Reid, R. & Torelli, L. (2002). *Educating and caring for very young children: The infant/toddler curriculum.* New York City: Teachers College Press. [chapter 1 only that include the case study]

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Case Study: Charlayne (4 months)

Charlayne's Mom reports that when she held her adopted daughter for the first time 3 days after she was born, she seemed to be a calm, even-tempered baby. She had a normal, healthy birth with no complications. At 4 months, Charlayne is still a 'predictable" child, who has slept through the night since she was 2 months old. Charlayne has black curly hair; large dark brown eyes, and light brown skin, attesting to her biracial heritage. She now weighs 10 ½ pounds, up 3 pounds from her birth weight, and is 3 inches longer than her birth length of 21 inches. Mom says she got on a feeding and sleeping schedule quickly and only fusses when she is tired or hungry. She now has rice cereal in her evening bottle; she is not taking cereal from a spoon.

Charlayne's muscle tone has been good from birth. She held her head up well and now she enjoys being pulled up to sit. Favorite positions are in her jumper chair or propped up on her parents' laps, where she watches everything going on, especially the actions of her 2 ½ year old sister and 7 ½ year old brother. She shows excitement when her brother comes home from school and greets her; and in new environments, she "takes everything in." Her mom thinks her motor development will be early because she is motivated by her siblings' activity. Her "social smile" started at 2 months, and now she laughs when her parents play tickling games at diaper changing or bath time. Her brother also makes her laugh by making faces and funny noises. Although she will lie quietly in her crib looking at her animals and mobiles, when she sees family members, she smiles broadly.

Charlayne's fine motor skills are developing well, and in the past two weeks she has held onto her bottle while in her mother's arms. When she is hungry and sees her bottle, she reacts by shaking in anticipation. She also reaches for and grabs objects, and tries to hold her pacifier and teething bear and bring them to her mouth. She likes reaching for and holding onto her hanging toys. She tries to flip or spin toys and watches her actions in the mirror. She has begun to look at books with her parents and she vocalizes often, especially when other family members are talking as they engage in tasks such as cooking dinner. Although she is fond of social interaction and her disposition is up-beat, when she is tired she wants her mom and cries until Mom takes her.

The family lives in a culturally diverse area, and they believe it is important for Charlayne and her sister (who is also adopted and biracial) to be exposed to many racial and cultural groups. They also want Charlayne to "be connected with all the family members" and not be treated any differently because she was adopted and looks physically different from her siblings. Because the family does not have much information about Charlayne's biological parents or the care received prenatally, they want to be sure that her development "stays on target".

Case Study: Eden (14 months)

Eden at 14 months is a slim child about 30 inches tall and weighing 20 pounds. She has creamy skin, reddish hair; a pixy-like appearance, and her dad's large gray-blue eyes.

Her slight build and small appetite have been an ongoing concern for her parents. Eden's mother says that in her early months, although physically helpless, she was assertive, letting her parents know when she needed something. She was fussy at times and never slept well, being on a day-for-night schedule. Eden nursed at least every 2 hours, but when introduced to the bottle at 6 months, she had no trouble making the transition.

She likes to load and unload a variety of objects in and out of any kind of container, including the household laundry basket and her toy box. Her parents say she is fascinated by animals and mimics their sounds, especially dogs barking. She loves to listen to her father play his guitar and strums it with his help. When music is played, she attempts to dance by twisting and turning her body even while sitting on the floor. She has discovered that the foyer in their home has interesting acoustics when she plays with her voice, talking or screaming.

Eden has been crawling since she was 6 months old, and now she pulls herself up on furniture and climbs on it. She is not yet walking well alone, however. She walks using push toys or a chair for balance, and spends time exploring different objects in her path. She has a rocking zebra at home that she repeatedly climbs on and off. A morning activity at home is to jump on her parents in bed, accompanied by squeals of laughter and vocalizing. Her favorite time of day is when her father arrives home from work. Once she knows he is home, she crawls to the door and waits for his entrance.

Eden enjoys crawling through a foam tube in her house, and she also loves balls and will carry them with her as she moves from around the house. Often she can be found sitting on the floor flipping through the pages of a book, talking to the books as though she is reading them.
Both parents express concern about Eden's eating habits and describe mealtime as an ordeal. She has to be distracted with props in order to get an adequate amount of food into her, which makes mealtime a long, drawn-out affair They say her pediatrician is concerned about her slow weight gain and poor appetite.

When Eden engages in unacceptable behavior; her parents speak to her in a gentle, matter-of-fact, but firm tone of voice that is usually effective. Her dad says that Eden is very sensitive to an adult's tone of voice and that they need to say "no" only once for her to respond. Once she backs off, they may need to comfort her if she is upset. It is still quite easy to distract her with a more acceptable object when one must be removed, however. Although they see Eden as basically happy, contented, and adaptable, they know it is important for Eden to have a sense of security.

Now Eden sleeps through the night except when she is hungry and wants a bottle. Overall, her parents describe her as a happy playful child who thoroughly enjoys being with Mom and Dad.

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Case Study: Nancy (24 months)

A slightly built 2-year-old who weighs 25 pounds and is 33 inches tall, Nancy has shoulder-length, white-blonde hair; fair skin, and blue eyes. She is active, alert, and in constant motion. Her other described her as being a hungry, demanding, and active infant She slept well at night but did not sleep more than 5 to 10 minutes during the day and only while she was nursing. She was fussy around 5:00 p.m. each day. Now Nancy still eats well, but she has developed a sweet tooth, according to Mom. Nancy and her mother have just moved to a new apartment (her mother is a single parent). Since moving, Nancy sleeps through the night only if she is in her mother's bed, and she will not take naps at home. Nancy has begun toilet learning and now has bowel movements in the toilet.

Nancy has many interests, mostly involving a lot of movement (gross-motor skills), and she prefers to be outdoors, rain or shine. She likes to jump on the sofa cushions at home. Her mother reports that Nancy is learning to put plastic bricks and puzzles together; and is putting on her own shoes. She occasionally watches children's videos but isn't interested in television. Mom says that she "gets nothing done" when she and Nancy are at home.

Parents describe Nancy as "a dynamo" who is always on the mover, although she does nap briefly each day. She tries to climb and jump off furniture. She is showing fine-motor skills, putting together pop beads and pulling them apart, and placing large puzzle pieces of geometric shapes in the correct spots. She enjoys listening to tapes of nursery rhymes and stories. She frequently uses the play phone to imitate adults talking, pausing and laughing as though responding to someone on the other end. She enjoys sensory activities like drawing and painting and sand and water play.

Both Nancy's parents agree that Nancy's activities are brief and occur in rapid succession due to her constant mobility. She flits around a room, changing activities about every minute. She likes to be with other children, although she watches or plays next to them rather than interacting.

Nancy's mother reports that Nancy has violent temper tantrums when she will kick and throw objects. Generally, Mom ignores her or tells her "You're really angry because ," She has found that time-out doesn't work with Nancy but that holding and rocking her while talking softly to her usually does. Redirecting her to another activity such as taking a soothing bath or watching a video also works.

Recently, Nancy was evaluated and was found to have a speech and language delay. The examiner found that her expressive language is in the 15-to-18 month range. She has just begun to mimic words said to her and has about 15 meaningful words in her vocabulary. Because of her delayed speech, she was found eligible for early intervention and will be receiving services to provide support to help her communicate better, which was the main concern and priority of Nancy's parents.

Case Study: Natalie (close to 3 years)

Natalie is a dark-haired, brown eyed child who is now close to 3 years old. Her parents nearly didn't make it to the hospital because her birth was so quick. She weighed 7 pounds, 15 ounces, was 20 ½ inches long, and had "only a fuzz" of hair. Although she now weighs over 28 pounds, she seems slim because she is tall for her age. Her parents recall that she was a calm infant who took her bottle every 3 or 4 hours and didn't cry much. Instead she "squeaked" when she wanted something. Her mother carried her around a lot because Natalie always wanted to be close, and even now she is her mother's "cuddle bug." Thus it was hard for her when the family had a new baby 3 months ago. Her father is her primary caregiver during her mother's workday, and in the past few months, her attachment to him has become even stronger. Her dad says, "She doesn't want to let me out of her sight," and she screams if he leaves the room or goes outside. She is also attached to her 4 year old sister and imitates many of her behaviors. The whole family is extremely close, spending most of their time together; Natalie's dad even takes them to see their mother at her lunch break at work.

Natalie's parents didn't notice any problems with Natalie's development at first. She sat up at about 7 months, loved her swing and her walker, and was a cooperative child. When she was 9 months old, they noticed that she tilted her head in a funny way when she reached for things, and she often was not successful in getting the object. Her dad says she had a "lazy eye," and her mom says she was "seeing double." Natalie underwent surgeries at age 1 and again in the past year to correct this problem. She will now have to wear glasses, and her mom is worried that she will resist wearing them.

Her parents think her development has been slow because of her eyes, saying that she had a set-back in activity after each operation. Although she walked at 12 months, she didn't crawl at all, and didn't reach for toys at that time. She has just now stopped drinking from a bottle (with much protesting), and is not yet potty trained. She never adjusted well to eating food that was lumpy or had texture; Mom says she would "act like she was gagging." Even now she eats mostly applesauce, soup, pudding, and other soft foods, although she has been feeding herself with a spoon since she was about 1 1/2. She understands almost everything said to her, such as "Throw your diaper away" and "Get in the bathtub," but her expressive language is delayed. She is now using a number of words, such as "bite," "hello," "hi," and "yeah," and she can say her brother's name (unclearly).

Natalie is presently in an Early Head Start program two mornings a week, and the interventionist also visits the home once per week. The early Head Start program has supported Natalie's physical, language, and social development and her home intervention provider has been supporting the family with strategies to help Natalie adjust more easily to changes in her environment and being able to tell them more clearly what she wants, which were the priorities of the family. Her parents believe that many of her delays are because of her previous vision problems. The intervention provider feels that there are a variety of factors that may be impacting her development in addition to her vision problems, including environment. The early intervention teams, including her parents feel that because the surgeries and glasses have improved her vision and she is making good developmental progress, she may not qualify for preschool special education services. The family has decided to enroll Natalie in Head Start at age 3.

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Her parents identify the following skills Natalie now has: getting dressed by herself, putting on her shoes, opening doors, answering the phone, and drinking from a sippy cup. After her eye surgeries, she didn't play much, and her play is still not elaborate as that of many children her age. Natalie's play includes doing shape puzzles, driving around Hotwheels cars (her dad collects them), pretending to feed her doll, "talking" to her troll doll, playing ball with her dad and sister, doing somersaults with her sister, making scribble drawings, playing a patty cake routine with Mom, and "dancing" with Dad to a favorite Kiss CD. She prefers watching videos, such as Barney. As to her personality, Mom says she is "her own person" but also "prissy," because she likes to wear dresses, in contrast to her older sister. Dad says she now cries when she doesn't get her own way, and he handles that by sending her to her room. Both parents believe she imitates behaviors of her older sister Natalie plays well with her and the neighborhood children.

Natalie's parents ensure that she wears her glasses regularly. The main outcomes her parents have for Natalie up until she turns 3 is that she will "say more" and "not be so clingy".

Case study: Stan (10 months)

Stan's parents knew from the prenatal amniocentesis examination that he had Down's Syndrome (trisomy 21, which is an extra chromosome); however, his mother experienced a normal pregnancy and he was born at full term, He weighed 8 pounds, 6 ounces, was 21 and three quarter inches long, and received an *Apgar score of 7. Unfortunately, 20 hours after birth he developed a septic infection, resulting in his heart stopping and a slow down to his breathing. He was placed in intensive care and remained there for 1 month. According to his dad, he was hooked up to "twenty wires and tubes," and heavy respirator use resulted in his getting a perforated lung, requiring that lung to be collapsed until healed. Because he had Down's syndrome, the medical staff thought that there may be abnormalities in his immune system, thyroid, and/or heart, and thus he had numerous tests to determine what physical abnormalities might have contributed to his illness. His dad says that he had "every medical test possible" during his first 6 months of life. His heart was monitored and he was on steroids until the determination was made that his physical systems (eyes, hearing, heart, intestines, immune system, and thyroid) were sound.

At his present age of 10 months, he is off of medication. His parents think that his early problems were a result of the infection. A few hours after his birth, his mother had a fever due to a mild bacterial infection, and she is worried that this may be been transferred to Stan at birth. Because the medical team knew of his disability, however; she feels that they saw him through that lens, and conducted extensive medical procedures to make sure no physical disability, common to children with Down syndrome, was a contributing factor to his early trauma, but did not take her concerns about the infection into consideration.

His mother reports that he was 8 days old before she was allowed to hold him and she could not begin breast feeding until he was 2 ½ weeks old. The traumatic start to his life may have had some effects on Stan's early social emotional experience; during the first month at home, he was shy with nonfamily members. His overall pleasant and outgoing temperament prevailed, however, and at 10 months, he is a responsive, warm, and friendly child. He is blond and blue eyed, just like his dad. He is an excellent sleeper now, sleeping 10 hours at night and taking two short naps. Stan now weighs 22 pounds and is 29 inches long. His head circumference is slightly smaller than typical. He is a good eater; "rarely missing a meal," and is beginning to feed himself cereal pieces. Both parents and medical personnel have remained very cautious about his health, as evidenced by the fact that his first fever (at 6 months) resulting in his spending the night in the hospital.

He was "involved with early intervention before he was born,", as the family had contacted the early intervention system as soon as they knew that Stan had Down Syndrome, actually before he was born! Since he was 3 months old, he has had an individual Family Services Plan (IFSP). Stan initially received visits from an early intervention specialist twice per month. When his IFSP was reviewed at 9 months of age, he was beginning to show more of a delay in gross motor activities. A priority of the family was that he would be able to get in and out of a sitting position by himself and begin to crawl. A consult from a physical therapist once per month was added.

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Presently Stan is showing many developmental strengths. His verbal skills include responsive cooing and babbling, laughing during parent play, understanding both physical and verbal cues, and vocalizing while playing with objects and people. He is responsive to faces but also enjoys toys, and he is curious about his environment. He watched his hands, tracked objects visually, and had a social smile at typical ages.

He began to roll at about 5 months but did not roll purposefully until 9 months. He can now sit securely when placed in position but doesn't get in and out of a sitting position easily by himself. He is not yet interested in crawling or standing.

His fine motor skills are developing, and he can now transfer objects from one hand to the other, pick up small cereal and pasta pieces, bang two objects together and take rings off (but not yet put them on) a stacking toy. He is beginning to clap his hands and drop objects in containers. He enjoys playing, turn taking and roughhouse games with Dad, such as "gonna get you" and being lifted in the air. He will also look at books when Mom holds and talks about them, and likes music and the color orange. He notices peers and has brief "object giving and taking" interactions with them. Stan's parents want him to explore and learn on his own with adult facilitation rather than direct instruction. They want Stan to be treated first as an individual, not as a "Down's child". Although they have valued the therapeutic assistance Stan has received, they are concerned that doctors and therapists have "preconceived notions," sometimes using words that describe the characteristics of Down syndrome, rather than the actual child's behavior (e.g., calling Stan's 3-month responses "floppy"). They don't want assumptions made without close observation of what Stan can do, and they want him to have the opportunity to master things on his own, rather than assuming he won't learn without intensive intervention.

Apgar Score
The very first test given to your newborn, the Apgar score occurs right after your baby's birth in the delivery or birthing room. The test was designed to quickly evaluate a newborn's physical condition after delivery and to determine any immediate need for extra medical or emergency care.

Although the Apgar score was developed in 1952 by an anesthesiologist named Virginia Apgar, you may have also heard it referred to as an acronym for:
Activity, Pulse, Grimace, Appearance, and Respiration.

The Apgar test is usually given to your baby twice: once at 1 minute after birth, and again at 5 minutes after birth. Rarely, if there are concerns about the baby's condition and the first two scores are low, the test may be scored for a third time at 10 minutes after birth.

A baby who scores a 7 or above on the test at 1 minute after birth is generally considered in good health. However, a lower score doesn't necessarily mean that your baby is unhealthy or abnormal. But it may mean that your baby simply needs some special immediate care, such as suctioning of the airways or oxygen to help him or her breathe, after which your baby may improve.

Early Intervention:
Concepts of Developmental Delays and Disability

Unique Characteristics of Infant/Toddler Services: Early Intervention

- The correct terminology to use to describe the age range of children eligible for early intervention is birth TO three OR children birth THROUGH two.
- Delay or disability can be difficult to diagnose at a young age – and thus "developmental delay" and "established condition" are used as the two categories for providing services. Some developmental lags may naturally or spontaneously disappear by school age. For example, some children say their first words by 18 months and others do not say their first words before 3 yrs. Even physical problems may not show before 6 months until primitive reflexes integrate. Primitive (infant) Reflexes are repetitive, automatic movements that are essential for development of head control, muscle tone, sensory integration and development. They form the basis of our postural, lifelong reflexes. When a baby has been given the opportunity to develop freely and naturally the primitive reflexes will integrate and no longer be active. When the primitive reflexes remain active then many difficulties can emerge.
- Primary responsibility for the intervention falls with family. Parent and caregiver are typically the primary mediators of intervention.
- Intervention strategies are best carried out in the natural routines of daily life.
- Intervention may have to address a multitude of domains – requiring multi-disciplinary expertise and even different agencies. For example, a child w/ cerebral palsy may not learn to sit up, hold a spoon or form first words or put together a simple puzzle without specific accommodations, instruction. Often extensive medical needs are involved. Consequently a team of professionals is needed from different disciplines and even agencies.
- How well a child progresses is greatly dependent on the parent's ability to provide for and support their child. For example, family experiencing poverty may not have sufficient of healthy food available, meaning that the child's nutrition is put at risk, A lack of transportation may mean appointments with professionals are missed. Parents who are exhausted and overwhelmed or who have experienced abuse or neglect themselves may mean there is a greater likelihood of abuse or neglect toward the child. Over protective parents may not allow the child a wide variety of experiences and interactions.

When differences are considered delay or disability?

- When the "when" or "how" of development is outside of what is considered "typical development**."**

- When a child has a physiological condition that is known to significantly affect development

Remember:

- **A Disability is a difference, not a deviance.** "Deviance" is a word with negative connotations. Children with special needs are more like other children than they are different. Their disability is not what defines them.
  - We need to view differences as merely differences rather than as deviance.
  - When we see deviance, we devalue people.
  - Any difference is only one part of who that child is.

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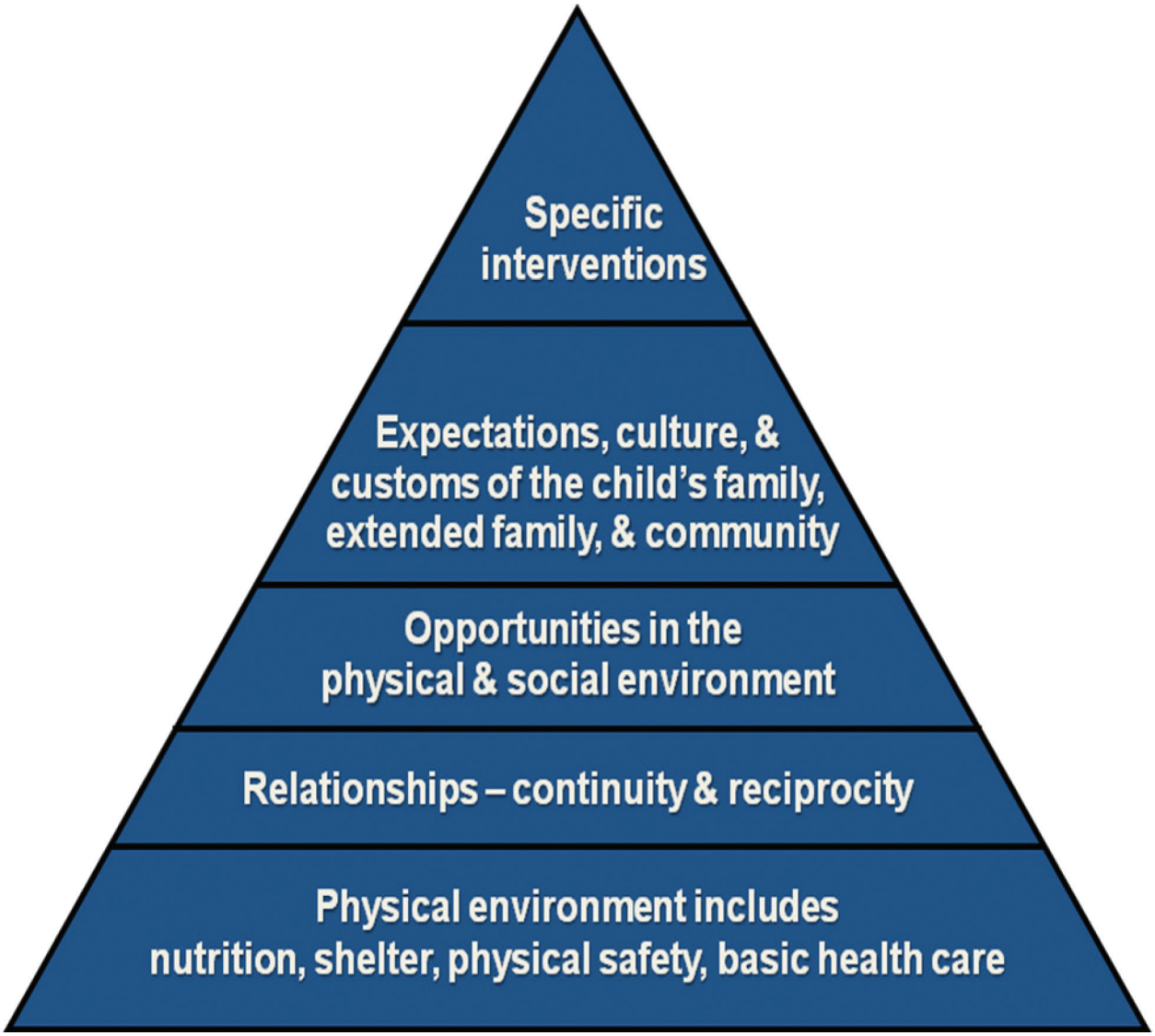
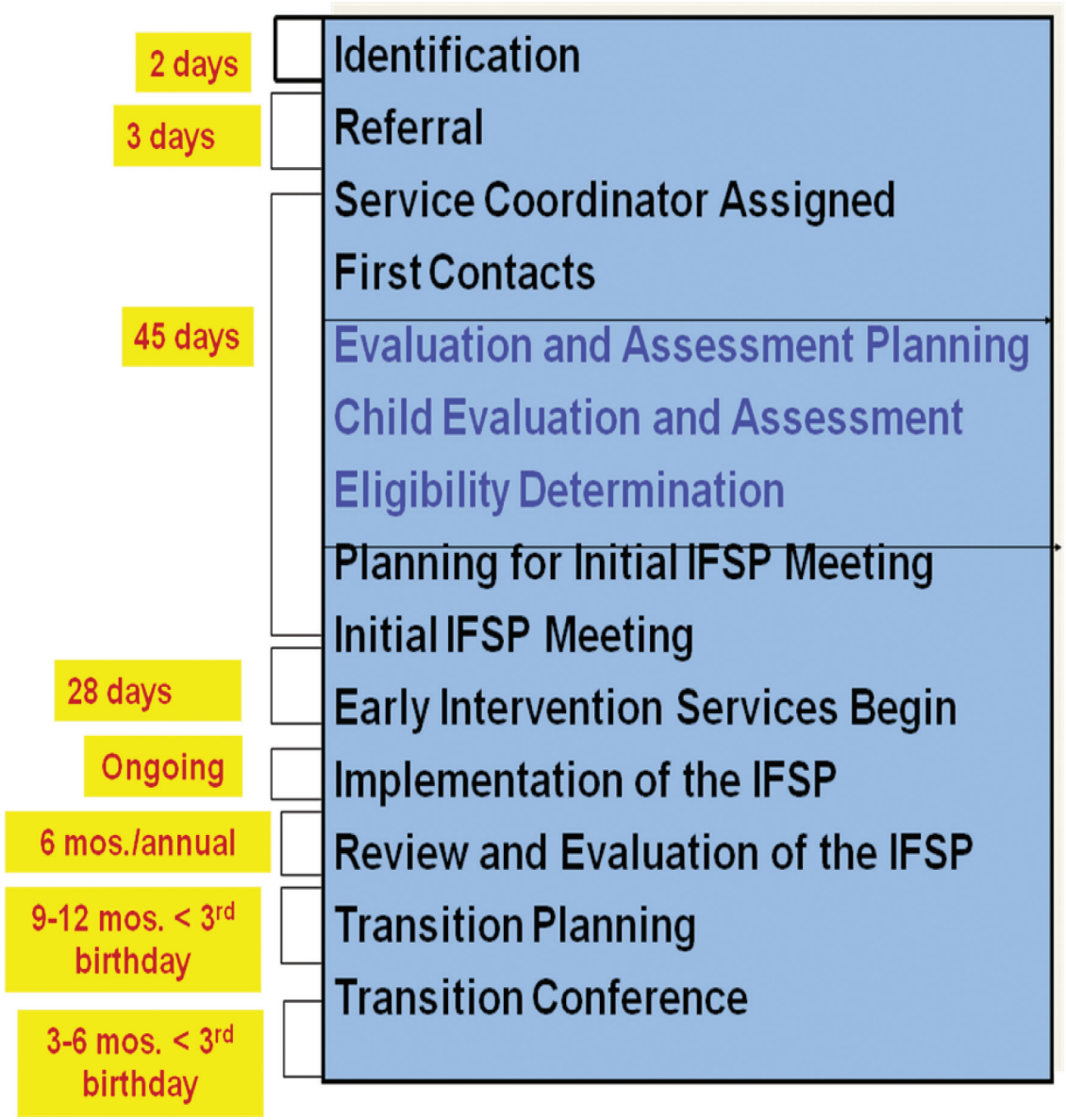
Pyramid of Developmental Influences

Stanley Greenspan, et al



Steps: From Referral to Exit for Early Intervention



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Early Intervention Eligibility Determination

Eligibility for early intervention is determined by each state's definition of developmental delay and includes children with established physical or mental conditions with a high probability of resulting in developmental delay.

States may choose to include children at risk for disabilities in the eligible group.

In Colorado, Community Center Boards are responsible for ensuring a local system of child find that includes public awareness, identification and referral, eligibility determination, and evaluation.

There are two ways/categories to determine eligibility for the Early Intervention System

Category #1*: Children who have a Developmental Delay:* having a significant delay in development in one or more of the following domains:

- thinking and learning skills (cognitive development)
- moving, seeing, and hearing (physical development)
- understanding and using sounds, gestures, and words (communication development)
- responding to and developing relationships with other people (social-emotional development)
- taking care of one's self when doing things like feeding or dressing (adaptive development)

Colorado's Definition of Developmental Delay In Colorado the rigorous definition of a "developmental delay" means an infant or toddler who has a 25% or greater delay in one or more areas of development when compared with chronological age or the equivalent of 1.5 standard deviations or more below the mean in one or more areas of development.

Category #2: *Children with an Established Condition:* having a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development

Conditions That May Be Associated with Delays in Development:

- Low birth weight infants weighing less than 1,200 grams
- Postnatal (after birth) acquired problems resulting in delays in development, including but not limited to severe attachment disorder
- Chromosomal syndromes and conditions (e.g. Down syndrome)
- Congenital syndromes and conditions
- Sensory impairments (some hearing and visual impairments)
- Metabolic disorders
- Prenatal or perinatal infections resulting in significant medical problems and health issues

People First Language

Permission has been granted for this document to be printed.

This document is available to print from website:
http://www.eicolorado.org/Files/People%20First%20Language%202009.pdf

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Use of People First Language Vs Labels

People First Language to Use	Instead of Labels that Stereotype and Devalue
• **people/individuals** with disabilities **an adult who has a disability** **a child with a disability** **a person**	• the handicapped the disabled
• **people/individuals** without disabilities **typical kids**	• normal people/healthy individuals atypical kids
• **people with** intellectual and developmental disabilities **he/she has a cognitive impairment** **a person who has Down syndrome**	• the mentally retarded; retarded people he/she is retarded; the retarded he/she's a Downs kid; a Mongoloid; a Mongol
• **a person who has** autism	• autistic
• **a person who has a learning disability**	• he/she is learning disabled
• **a person who is deaf** **he/she has a hearing impairment/loss** **a man/woman who is hard of hearing**	• the deaf
• **person who is deaf and cannot speak** **who has a speech disorder** **uses a communication device** **uses synthetic speech**	• is deaf and dumb mute
• **a person who is blind** **a person who has a visual impairment** **man/woman who has low vision**	• the blind
• **a person who has a learning disability**	• he/she is learning disabled
• **a person who has epilepsy** • **people with a seizure disorder**	• an epileptic a victim of epilepsy
• **a person who** uses a wheelchair **people who have a mobility impairment** • **a person who walks with crutches**	• a person who is wheelchair bound • a person who is confined to a wheelchair • a cripple
• **a person who has** quadriplegia • **people with paraplegia**	• a quadriplegic • the paraplegic
• accessible **buses, bathrooms, etc.** **reserved parking for people with disabilities**	• handicapped buses, bathrooms, hotel rooms, etc. handicapped parking
• **he/she is of small or short stature**	• a dwarf or midget

Resources

Law and Policy:

1. http://www.disabilityresources.org/ABC.html : This website provides a quick guide to some of the more common acronyms in disability education, law, medicine and rehabilitation.
2. http://idea.ed.gov/explore/home: This is the U.S. Department of Education, Office of Special Education Programs' (OSEP's) website on IDEA.

Parent Groups

3. http://www.peakparent.org/ :PEAK Parent Center is Colorado's federally designated Parent Training and Information Center (PTI). PEAK assists families and others through services like its telephone hotline, workshops, conferences, website, and publications.
4. http://www.pacer.org/index.asp. The PACER Center (Parent Advocacy Coalition for Educational Rights) helps to expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents.

Specific Disabilities

5. http://www.thearc.org/ The Arc is the world's largest community based organization of and for people with intellectual and developmental disabilities.
6. http://www.ucp.org/: United Cerebral Palsy (UCP) is the leading source of information on cerebral palsy and is a pivotal advocate for the rights of persons with any disability.
7. http://www.ndss.org/ The National Down Syndrome Society is the national advocate for the value, acceptance and inclusion of people with Down syndrome.
8. http://www.nationalautismassociation.org/index.php The National Autism Association educates and empowers families affected by autism and other neurological disorders.

Early Intervention

9. http://www.zerotothree.org/ 0-3 is a national nonprofit organization that informs, trains and supports professionals, policymakers and parents in their efforts to improve the lives of infants and toddlers.
10. http://www.nichcy.org/ National Dissemination Center for children with Disabilities (NICHCY) is a central source of information on: disabilities in infants, toddlers, children, and youth; IDEA; No Child Left Behind (as it relates to children with disabilities); and research-based information on effective educational practices.
11. http://www.dec-sped.org/ The Division for Early Childhood (DEC) is one of seventeen divisions of the Council for Exceptional Children (CEC) – the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. DEC is especially for individuals who work with or on behalf of children with special needs, birth through age eight, and their families

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Homework Assignment

- With a partner, pick a website from the list on Resource handout (H24).

- Research/ review the website based on the following criteria:
  - What is the information provided on this website?
  - What age range of children does the website cover?
  - Who does the website primarily cater to- service providers, policy makers, researchers, or families?
  - How will this website help you in you work with children and families?

- Write a report and submit it to the instructor.

Early Intervention Orientation Academy for Developmental Intervention Assistant Resource List

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Early Intervention Orientation for Developmental Intervention Assistant

Reference and Website Resource List

Early Intervention Colorado website eicolorado.org website. http:/www.eicolorado.org/index.cfm?

"Transdisciplinary Team/Primary Service Provider Model". The brochure can be downloaded at http://www.eicolorado.org/Files/Transdisciplinary_PSPBrochure_FINAL.pdf?CFID=7923341&CFTOKEN=83131318

The brochures can be ordered at Early Intervention Colorado by visiting their website: www.eicolorado.org or calling 1-888-777-404.

"If Babies Come with Manuals" on PBS. The "video" picture has the hyperlink. If you click on the picture in the "slideshow mode", it should take you to the website. The website link is: http://www.pbs.org/parents/earlylearning/babycues.html.

Child Development Video #1 slide (**Slide 123**) from Centers for Disease Control (CDC) to review some developmental milestones in young children. The link http://www.cdc.gov/CDCtv/BabySteps/ - will take you to the website.

Child Development Video #2 The link to this video is provided in the slide as well as below. (This video is available at: http://abavtooldev.pearsoncmg.com/myeducationlab/singleplay.php?projectID=mcdevitt.ormrod&clipID=Cognitive_Development_Infancy.flv)

N*ational Dissemination Center for Children with Disabilities* website if they are interested in learning more about Categories of disability for Part B: http://www.nichcy.org/InformationResources/Documents/NICHCY%20PUBS/gr3.pdf

"People First Language" by Kathy Snow**. T**he article can be downloaded from the following website: http://www.eicolorado.org/Files/People%20First%20Language%202009.pdf

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