Early Intervention Home-Visiting Principles in Practice: A Reflective Approach

The home is the most frequently used location for providing early intervention supports and services (U.S. Department of Education, 2006). However, practices to address child development outcomes have shifted from direct, hands-on “treatment” to supporting families through collaboration and consultation so that they can promote their child’s development by using identified intervention strategies effectively and confidently during their everyday activities (Bailey et al., 1998; Bruder, 2000; McWilliam, 2000a; Shelden & Rush, 2001). Routine activities, those everyday family experiences, provide rich opportunities for promoting child development. For example, mealtime might not only be a time for learning eating skills but can also provide opportunities to develop communication and socialization skills. Interventionists support families’ use of these routine activities as learning opportunities by embedding intervention strategies, individualized to the unique learning characteristics of the child into the routine activities.

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The context of the early intervention home visit is the individual family’s routine activities. The shift in home visiting practices is aligned with Division for Early Childhood of the Council for Exceptional Children recommended practices. Practices regarding child-focused interventions include considering the setting (i.e., routine activity) in intervention design, ensuring strategies can be used across settings where children learn, and promoting child engagement with other people and materials (Wolery, 2000). A recommended practice for interdisciplinary models is “team members focus on between-session time (i.e., build in activities that can be carried out across time and contexts)” (McWilliam, 2000b, p. 54).

Although home visiting consultation practices are endorsed, early interventionists might have difficulty implementing these practices, especially when they have been trained to be more hands-on and directed toward the child rather than the caregiver and child (Bruder, 2000; Shelden & Rush, 2001). The purpose of this article is to guide early interventionists’ reflections on their own home visiting practices with respect to recommended practices. The practices discussed are specific to the times during home visits when intervention is focused on child learning outcomes. There most likely will be other times when the home visit focus is on other family outcomes, where these practices might be modified to reflect the different focus.

Critical Home Visiting Components

Research and practice literature have identified four overarching home visiting components to facilitate child learning and development. Home visits should (a) occur within the context of the family’s routine activities, (b) promote child engagement, and build family capacity by (c) ensuring caregiver engagement in the home visit and (d) supporting caregiver confidence and competence in their use of the intervention strategies (Bailey, 2001; Bailey et al., 1998; Brooks-Gunn, Berlin, & Fuligni, 2000; Bruder, 2000; Dunst, 2000; Dunst, Bruder, et al., 2001; Kaiser & Hancock, 2003). Each of these components is discussed below, with each section beginning with a question interventionists can consider as they reflect on their practices.

Context

How are the family’s routine activities used as the setting for home visits?

The context of the early intervention home visit is the individual family’s routine activities (Dunst, Bruder, et al., 2001; McWilliam, 2000a). These routine activities may be specific events, such as reading books after lunch, or simply times of the day, such as before or after the child’s nap. To identify and use these routine activities, interventionists and family members can discuss why home visits occur during routine activities. The conversation might include that all children, those with and without disabilities, learn best within the routine activities where they will use new skills, which also provides multiple opportunities throughout the day and week to practice emerging
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The routine activities used during home visits are individualized based on the family’s interests and priorities. These may be times that the family has specific concerns but can also include times that are enjoyable or relaxed, such as walking through their flower garden or choosing clothes to wear as opportunities to learn colors. Families may feel that their child is learning throughout the day and may not identify specific routine activities. However, it may not be enough to use just any “typical” routine activity, such as eating, getting dressed, or playing together. Instead, interventionists and families can collaborate to identify those routine activities that make sense for the individual family (Dunst, Hamby, Trivette, Raab, & Bruder, 2000). Considerations in identifying routine activities that make sense for the individual family include family values and priorities (e.g., it is important to the family that the child and siblings play together), child interests (e.g., the child likes to watch the construction vehicles building in their neighborhood), child needs (e.g., the child has a hard time transitioning to and participating in the bedtime routine), and/or restrictions on the family’s time (e.g., the family does not want to embed strategies around following directions during weekday breakfast because of the hurried nature of the morning routine).

Finally, context includes the family’s customs and practices. For example, the family may be interested in understanding the best way to play interactive games with their infant. Instead of the interventionist suggesting specific songs and finger plays the interventionist knows, the interventionist can ask the parents to identify those that are a part of the family’s culture, perhaps ones remembered from their childhood. Intervention strategies can then be integrated into the family’s customs to promote child interaction and engagement.

**Child Engagement**

*How does the home visit support active child participation in the family’s routine activities to promote child learning?*
The learning opportunities available in routine activities can be capitalized on when the child is engaged by participating in the routine activity in developmentally and individually appropriate ways (Dunst, 2000; Dunst, Bruder, et al., 2001; Dunst, Trivette, Humphries, Raab, & Roper, 2001). Considerations in creating engagement include, but are not limited to, active involvement, interest, and motivation to learn. A child is not engaged when he is being distracted from an activity happening to him, such as when given a toy to play with while his face is washed to provide oral motor stimulation before eating. Interventionists and caregivers can be creative and try to find ways to engage the child and opportunities for child initiation during the activity, two early features of self-determination (Erwin & Brown, 2003). From the example above, engagement and initiative might be built into the activity by having the child “tell” the caregiver when he is ready to have his face washed or hold a face cloth and imitate face washing while the caregiver is washing his face.

Child interest either occurs naturally because the child is already interested in the routine activity, or interest is intentionally built into a routine activity as part of intervention, considering the individual child’s motivations (Dunst, Bruder, et al., 2001; Dunst, Trivette, et al., 2001). For example, whereas some children might be motivated by singing, another child might not become interested using such an approach. The family and interventionist can collaborate to identify the child’s interests that might facilitate engagement and learning.

A child is motivated to learn when the activity is designed to be just enough of a challenge that the child understands what is expected and can figure out the aim of the activity (Keilty & Freund, 2004). Adaptations can be made by modifying materials or changing the arrangement of the physical environment and by using responsive caregiving strategies to support the child’s motivation to try to be successful (Campbell, 2004).

Through interventionist and family collaboration, strategies to promote child engagement are identified and tried to determine their effectiveness. If the engagement strategies do not seem to be working during the home visit, other strategies should be attempted while the interventionist is available to problem solve with the family. Although the family may have many ways to engage the child in routine activities, the interventionist and family should ensure the engagement strategies are successful within the specific routine activities where intervention strategies are embedded. The family should not be left with only potential strategies that may or may not work or with interventionist recommendations that the family keeps trying even though the child was not engaged when it was attempted during the home visit. Without the strategies to promote child engagement, caregiver disengagement in future home visits might result.
Caregiver Engagement

How is the caregiver actively participating so that she or he can learn specific intervention strategies?

Caregiver use of intervention strategies between home visits begins with caregivers’ feeling comfortable engaging and actively participating in the home visit (Brooks-Gunn et al., 2000; Ruggman, Boyce, Cook, & Jump, 2001). Wagner and colleagues (Wagner, Spiker, Linn, Gerlach-Downie, & Hernandez, 2003) identified five dimensions of caregiver engagement: presence, availability, involvement, application of support strategies, and exploration of additional supports. The extent to which caregivers are engaged can be dependent on the way the home visit is structured or other influences in the family’s life.

Before caregiver engagement can be facilitated, the interventionist must understand the caregiver’s expectations of early intervention. Caregivers may perceive early intervention to be comparable to traditional child-directed clinic or classroom services. During home visits, interventionists must be clear as they discuss, and consistent as they practice, to support caregivers’ understanding of their roles as appreciated, active participants. Interventionists and caregivers might discuss what participation could look like. Different ways the interventionist might participate include asking questions and listening to the caregiver, explaining and demonstrating how to use certain strategies, and providing feedback to the caregiver. The caregiver can participate in the home visit by asking questions and clarifying statements, observing the interventionist’s demonstrations, trying out the strategies, and providing feedback to the interventionist (Kaiser & Hancock, 2003; Rush, Shelden, & Hanft, 2003; Woods, Kashinath, & Goldstein, 2004). From this conversation, consensus on what early intervention home visiting looks like can be achieved.

Encouraging caregiver participation from the inception of home visits as well as at the beginning of each home visit can convey its importance. Providing a few “warm-up sessions” in the initial home visits or a few minutes of the interventionist and child alone at the beginning of each visit, where the caregiver passively watches or is not in the room, can convey to the caregiver that she or he does not really need to be, nor is valued as, a collaborator in the home visit. This can further reinforce a direct child treatment model. Shifting from an interventionist–child model to a caregiver–child with interventionist support model can be more difficult than using the desired model from the beginning. Caregivers may also be confused about how to participate in home visits if some team members are encouraging caregiver participation and others are not. Open communication among all team members, including the family, is critical to ensuring everyone sees the value in collaborating with caregivers so they feel comfortable engaging in home visits.

Home visits can be designed so that caregiver engagement is
anticipated and necessary. Scheduling home visits during a routine activity the caregiver sees as a learning opportunity can build engagement because it is aligned with the caregiver’s priorities. If the caregiver appears disengaged, the interventionist and caregiver can discuss the purpose of home visiting, whether it is a good time for the visit, and whether the visit should be rescheduled if the caregiver cannot participate at the scheduled time. Another strategy is to ask the caregiver what she or he is doing instead of participating in the home visit (i.e., the real routine activity of the moment) and whether that routine activity might be an opportunity to embed intervention strategies.

If the caregiver is not participating in the visit, the interventionist and caregiver can collaborate to uncover possible reasons for the caregiver’s reluctance. The family may have time constraints of which the interventionist is unaware, or the family may not truly understand or embrace the importance of participation. The plan and resulting interventions may not be meaningful to the caregiver if they are not designed according to the family’s true goals. The caregiver may not feel comfortable with the strategies if they are difficult to embed into routine activities. Encouraging families to discuss their concerns about participating in home visits can provide an opportunity to problem solve. For example, the conversation may reveal that the home visit is the only time the caregiver can “take a break.” With this knowledge, the interventionist and caregiver can brainstorm strategies to address this need, including identifying informal supports, such as family, friends, and neighborhood babysitters, as well as more formal sources of support, such as respite services. The purpose of this conversation is to meet the caregiver’s priorities and open the door for active caregiver participation in the home visit.

Lack of caregiver engagement may also result from pressing family issues that interfere with the caregiver’s attention. For example, a caregiver may be present for the visit but busy coordinating the child’s doctor’s appointments. Or the caregiver may be involved in the visit but seem very tired and disinterested because she or he is occupied with moving her or his aging parents closer to home. At times such as these, there may need to be a shift from child-focused visits to family-focused visits in order to support the family in addressing these priorities.
As mentioned previously, early interventionists are not always trained to work with families. This may result in interventionists’ feeling uncomfortable engaging in conversations with families about caregiver participation. Interventionist discomfort in this consultation role can negatively influence caregiver participation, as caregivers may sense the professional’s uncertainty with these practices. Interventionists can take time to reflect on their own feelings about consulting with families. They can explore research and practice articles on collaborating with families, seek outside professional development opportunities, and use supervisory and peer mentors to examine these concepts of practice deeply. As interventionists gain more knowledge of and competence in working with families, they will feel more comfortable engaging in conversations necessary for an open and equal partnership with families.

**Caregiver Competence and Confidence**

*How does the home visit ensure the caregiver can accurately utilize the intervention strategies?*

Caregivers can and do learn how to use intervention strategies to promote their child’s learning and development effectively (e.g., Kaiser & Hancock, 2003; Mobayed, Collins, Strangis, Schuster, & Hemmeter, 2000; Woods et al., 2004). To facilitate caregiver confidence and competence in using recommended intervention strategies, home visits are designed in terms of both approach—how home visits are implemented—and content—what strategies are recommended. The literature recommends various approaches to facilitate effective strategy use. These approaches usually comprise some combination of discussion and explanation (verbal and/or written), modeling, and practice with feedback (Dunst, Bruder, et al., 2001; McWilliam & Scott, 2001; Rush et al., 2003; Woods et al., 2004).

When specific strategies are discussed, a rationale for how the strategies will address the family’s priorities and outcomes can increase caregiver “buy-in” to learn the strategies. For example, a caregiver who understands the link between oral motor techniques and the family’s goal of communicative competence is more likely to use the strategies than a caregiver who perceives the oral motor techniques as “exercises to help strengthen the child’s muscles.” Although some strategies may only need to be discussed with the caregiver, such as putting toys in the bathtub as a source for play and interaction, other strategies will need to be demonstrated and practiced. Modeling provides an opportunity for caregivers to observe interventionists demonstrating strategies within the routine activities (Kaiser & Hancock, 2003). However, what might appear to be modeling might really be direct child instruction between the interventionist and the child, with the caregiver present but passively observing the intervention (e.g., sitting on the couch watching; McBride & Peterson, 1997). For true modeling to occur, the interventionist is actively demonstrating the strategies with a full explanation of what she or he is doing and thinking about while engaged in
Ongoing, open communication between caregiver and interventionist is necessary to ensure that the caregiver is truly comfortable using the strategies.

A two-way conversation with the caregiver. After modeling occurs, caregivers need the opportunity to practice and receive feedback on use of the strategies so that both the interventionist and caregiver are confident that the caregiver can use the intervention strategies accurately.

Ongoing, open communication between caregiver and interventionist is necessary to ensure that the caregiver is truly comfortable using the strategies. Interventionists can encourage caregivers to ask questions and identify possible reservations in using the strategies so they can be addressed. For example, an interventionist might coach a caregiver in positioning the child on her or his lap, facing her or him, while swinging on their backyard swing, to promote interaction and increase use of muscles. By reading the caregiver’s cues and asking for feedback, the interventionist might discover that the caregiver feels uncomfortable transitioning into that position and feels unsteady once on the swing. The interventionist and caregiver can collaborate to (a) identify new ways to get into the position and feel stable on the swing, (b) find other ways to promote learning and interaction while on the swing, and/or (c) identify other routine activities where the same competencies can be addressed, such as when they are sitting on the rocking chair on the porch. Receiving feedback on the strategies attempted allows the interventionist to tailor the strategies to the caregiver’s preferences and comfort. The approaches chosen to support caregiver strategy use will most likely be different for each individual family depending on the child’s characteristics and the caregiver’s learning style. The approaches will also vary within the same family depending on the complexity of the strategies recommended.

When discussing potential intervention strategies, consideration is made as to whether the strategy is functionally relevant to the child’s life (e.g., does the strategy make sense based on the routine activities?) and easy, or “doable,” for the caregiver to use in routine activities (Dunst, Trivette, et al., 2001; McWilliam, 2000a). Interventionists can monitor the home visit by asking, If the interventionist is taken out of the routine activity, can the strategies suggested still occur? For example, if the interventionist is holding the child while the caregiver is trying a strategy for putting on the child’s shoes, the strategy suggested might not work when the interventionist is unavailable to assist. Home visitors can be attuned to what the routine activities usually look like so that the caregiver can more easily use the strategies in everyday life.

The amount of support needed to use recommended strategies effectively, and the types and number of strategies perceived as reasonable, will vary for each family. The interventionist and caregiver can decide together the frequency and intensity of support needed, as well as the number and kinds of strategies with which the caregiver feels comfortable (Jung, 2003; Woods et al., 2004).
Reflecting on Home Visiting Practices

Early interventionists can enhance home visiting effectiveness by reflecting on their own practices in accordance with the recommended practices around using routine activities as the intervention context, facilitating child and caregiver engagement, and supporting caregiver confidence and competence in strategy use. The Home Visiting Principles Checklist (Table 1) was designed to assist early interventionists in this reflection.

The Home Visiting Principles Checklist is divided into the four overarching components of home visiting practices. The questions under each section correspond to the defining concepts of each component discussed in this article. The checklist was developed through a review of early intervention practices and is designed to assist early interventionists in reflecting on their own practices in accordance with the recommended practices around using routine activities as the intervention context, facilitating child and caregiver engagement, and supporting caregiver confidence and competence in strategy use.
intervention research and practice literature and individual and group professional development activities around implementing home visiting practices. The checklist was used in an early intervention home-visiting workshop to guide discussion on the practices observed in videotaped home visits. In evaluations of the workshop, participants reported that the checklist was very valuable to use as they reflected on their own practices.

The Home Visiting Principles Checklist can be used periodically during preservice practica or professional supervision and mentoring experiences. After an observed home visit, the interventionist and mentor can each complete the checklist and use it as a discussion guide. An action plan can then be developed, identifying specific areas to strengthen and potential strategies for strengthening them. Interventionists, alone or in partnership with a mentor, can also use the checklist to review possible intervention aspects that can be further considered when having difficulty partnering with a specific family. The checklist provides an opportunity for interventionists to consider possible modifications that may contribute to the success of their home visits.

Setting Home Visiting Expectations

It should be noted that home visits are only one part of the intervention process. There are multiple phases prior to the initiation of home visits that can be used to organize the intervention team around recommended home visiting practices. During team meetings or mentoring sessions, intervention teams can reflect on how they discuss early intervention with families upon initial contact and ways to tailor the discussion according to each family’s assumptions about early intervention (e.g., Does the family think early intervention is a place to receive physical therapy sessions?). Focusing the evaluation and assessment process on the family’s priorities and routine activities, and child learning within those routine activities, can further set the stage for home visiting. The Individualized Family Service Plan can include outcomes that are truly the family’s goals and functional within the family’s routine activities as well as strategies that include family participation. If the family has already been receiving early intervention supports, understanding what home visits have looked like in the past can facilitate a conversation about the similarities and differences in home visiting approaches.

Conclusion

Early intervention home-visiting practices have shifted to a consultation model where caregivers are supported in facilitating their child’s engagement and learning in the routine activities of everyday life. Interventionists can further enhance their work with families through reflection and consideration of their current practices in light of these recommended practices.

Note

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References


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