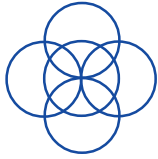


Birth to 6 EVENTS



Waisman Center

A BULLETIN FOR THOSE WHO WANT TO LEARN MORE ABOUT SERVING YOUNG CHILDREN WITH SPECIAL NEEDS AND THEIR FAMILIES

Issue 60—Fall 2008

Wisconsin Infant and Early Childhood Mental Health Conference

Early Relationships Matter: Building Networks

-Arianna Keil, WPDP

On June 18-20, 2008, the first Wisconsin Infant and Early Childhood Mental Health Conference was held in Madison. Coordinated by Wisconsin Alliance for Infant Mental Health (WI-AIMH), the event consisted of one preconference day featuring three separate all-day sessions, followed by two regular conference days offering keynote speakers and numerous breakout sessions. Nearly 400 people from across the country attended the three-day event.



Preconference day attendees selected one full-day session on reflective practice, the Center on the Social and Emotional Foundations for Early Learning's (CSEFEL) new parent modules, or using the DC: 0-3R in assessment and diagnosis of mental health concerns in young children.

There has been quite a buzz in the popular press around infant mental health lately. But what exactly is infant and early childhood mental health? Often times when we think of adult mental health, we think more of psychiatric disease rather than health.

Infant mental health is different. It is more inclusive of both health and disease states. Another difference is that infant mental health must take into consideration the mental well-being of the child's caregivers.

Wisconsin recently had its first conference on these issues, coordinated by the Wisconsin Alliance for Infant Mental Health. Early childhood professionals from across the nation attended, networked and shared ideas.

Many articles in this issue of EVENTS were topics covered at the conference, including the impact of maternal depression on young children, and the new Center on the Social and Emotional Foundations for Early Learning (CSEFEL) parent materials. This issue also contains a parent recommendation on a book designed to promote speech development and more on adult learning strategies as your program considers working in a transdisciplinary fashion (see Giving it Away on page 13).

-Arianna Keil, editor



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The first regular conference day opened with remarks by Reggie Bicha, secretary of the new Department of Children and Families. Gerard Costa, PhD, a developmental psychologist specializing in infant mental health from New Jersey, then discussed the principles of the field and the moral, ethical and economic imperatives around mental health promotion and early intervention at the opening keynote presentation. Multiple breakout sessions followed. Session topics ranged from the role of managed care in infant mental health promotion, to the importance of sensory play, to working with families.

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IMH CONFERENCE

The first conference day included an evening reception and award ceremony in memory of the late James R. Ryan. "A major highlight of the conference was the presentation of the James R. Ryan Memorial Award," noted WI-AIMH Director of Professional Development and Resources Lana Nenide. "This award is intended for an individual who has made a significant contribution to the social-emotional well-being of infants, young children, and their families. The nominating committee unanimously selected Therese Ahlers as the first recipient of this award. Ahlers is the founding director of WI-AIMH and a nationally recognized advocate for the well-being of infants, young children and families." The day closed with a presentation for parents and professionals on discipline strategies by Mary Sheedy Kurcinka, author of *Raising Your Spirited Child*.

The final day of the conference included more breakout sessions on topics such as maternal mental health and its impact on child development, the importance of sleep for maximizing children's health, development and performance, and how dimensions of poverty influence brain development. Participants listened to University of Wisconsin's Roseanne Clark, PhD, over lunch as she outlined a relational approach to working with mothers with depression and their infants.

Wisconsin Alliance for Infant Mental Health staff includes Theresa Ahlers, MS, MPA, Director, Janna Hack, LCSW, Conference Planning Chair and Infant Mental Health Consultant, Deana Hipke, BA, Administrative Assistant, Lana Nenide, MS, Director of Professional Development and Resources, and Lisa Tate, BS, Conference Consultant and Planner. "Overall,

the conference was an overwhelming success," stated Nenide. "WI-AIMH would like to thank the many sponsors and individuals who assisted with funding, planning, organizing and volunteering for this event." ☺



Birth to 3 WISLINE

December 11, 2008, 1:00-2:30 pm

Topic: Parent-to-Parent of Wisconsin

Description: Parent to Parent of Wisconsin provides parent support to parents of children with special needs through a one-to-one connection with another parent who has similar experience and who knows firsthand about the feelings and realities that come with having a child with special needs.

Presented by Robin Mathea, Director

<http://www.p2pwi.org/>



Maternal Depression and its Impact on Child Development

-Arianna Keil, WPDP

Information from WI-AIMH Conference session on Maternal Mental Health, Maternal Infant Attachment and Child Development: Important Aspects to Consider in Early Intervention Practice presented in June 2008 by Kris Pizur-Barnekow, PhD, OTR and Jennifer Runquist, PhD, RN, UW-Milwaukee

Maternal depression, also called postpartum depression, is a mood disorder occurring after childbirth. It affects around 13% of women on average, but 25-45% of women who are minorities from low-income, and/or low-support environments. Although nearly half of all cases of maternal depression go unrecognized, this disorder is very treatable with therapy and medication.

Many symptoms of maternal depression are similar to major depression. Others are unique, and include intrusive thoughts of harming the infant, extreme anxiety or guilt, anger or agitation, obsessive thoughts of inadequacy as a parent, difficulty sleeping despite extreme exhaustion, feeling disconnected from the infant and feeling loss of control over one's life. The diagnosis requires that symptoms be present for at least one month and cause some impairment in daily functioning.

Significant risk factors for maternal depression include previous episodes maternal depression, depression or anxiety in pregnancy, history of depression at other times, family history of depression or mood disorder, and current or recent stressful life events (such as trauma, poverty, violence or birth of an ill child).

The evidence is clear that maternal depression affects not only the mother herself, but her child as well. Depressed mothers are less affectionate and responsive to their infant's cries, engage in harsher discipline

practices for children aged 2-4 years, are less attentive to hygiene and safety, play and talk less with their infants, have fewer positive interactions with their child, are more likely to view their infant as bothersome, are more likely to withdraw from their infant and are more likely to demonstrate an anxious or avoidant attachment style.

As compared with infants of non-depressed mothers, infants of depressed mothers make fewer positive facial expressions and vocalizations, are more likely to exhibit poor weight gain, failure to thrive, feeding problems, sleeping problems, and poor emotional attachment. Looking ahead, maternal depression is considered one of the most significant mental health issues impeding children's readiness for school (Mental Health Policy Panel, Department of Health Services, 2002). Children of mothers with depression can develop sleep disorders, poor self-control, difficulty trusting others, self regulatory disorders, aggression, and poor relationship skills (Onunaku, 2005).

Professionals caring for mothers and infants, such as early interventionists, physicians, and WIC Clinic staff are well positioned to consider screening mothers for maternal depression. Several well-validated, brief and free screening tools exist to help identify mothers at higher risk. Like other screeners, these tools do not result in a diagnosis; they simply tell you which mothers need additional evaluation, and which likely do not.

For pregnant mothers or mothers of children aged birth up to 1 year of age, the Edinburgh Postnatal Depression Scale (EPDS) is a 10-question screener. Each question has 4 choices of responses. The Center for Epidemiological Studies – Depression (CES-D) is often recommended to screen women with children over one year of age. The CES-D consists of 20 questions, and respondents are asked how often they have experienced certain depressive symptoms within the past week. Referrals for a more complete evaluation should be made to a qualified mental health professional for women with concerning screening results.

With appropriate treatment, often including therapy and/or antidepressant medication, most women recover from maternal depression. As they benefit from treatment, so do the children for whom they care. ☺

References:

Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA. Los Angeles CA

Postpartum Depression Screening Guidelines and Consumer Education Resources

courtesy of Kris Pizur-Barnekow, PhD, OTR and Jennifer Runquist, PhD, RN, UW-Milwaukee

1. For consumers:
<http://mchb.hrsa.gov/pregnancyandbeyond/depression/>
2. Interventions for Postpartum Depression (Best-practice guidelines for postpartum depression screening).
The full pdf can be opened if you scroll to the bottom of this page.
<http://www.rnao.org/Page.asp?PageID=828&ContentID=806>
3. National Guidelines Clearinghouse:
http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=7196&nbr=&string
4. Maternal-Child Health Library out of Georgetown University:
http://www.mchlibrary.info/KnowledgePaths/kp_postpartum.html
5. Wisconsin Association for Perinatal Care has a focus on perinatal depression:
http://www.perinatalweb.org/index.php?option=com_content&task=view&id=20&Itemid=37

WAPC's position paper, which includes a framework for screening, is located here:
http://www.perinatalweb.org/images/stories/PDFs/Materials%20and%20Publication/screening_perinatal_postpartum.pdf

Validated screening tools can be accessed here:
<http://www.perinatalweb.org/index.php?option=content&task=view&id=86>

6. Postpartum Support International:
<http://postpartum.net/resources/>
7. Website for mothers and fathers suffering from depression:
<http://www.postpartumcouples.com/>

ARCHIVED Birth to 3 WISLINE

To hear the September 11, 2008 Wisline on this topic, go to

<http://www.uwex.edu/ics/stream/session.cfm?eid=11107&sid=16563>



Positive Solutions for Families: Promoting Children’s Social Emotional Development and Addressing Challenging Behaviors with CSEFEL’s Parent Materials

-Arianna Keil, WPDP

Center on the Social Emotional Foundations for Early Learning (CSEFEL)
online at <http://www.vanderbilt.edu/csefel/>


The Center on the Social Emotional Foundations for Early Learning, or CSEFEL, aims to promote social and emotional development and address challenging behavior of young children birth to age 5. Currently housed at Vanderbilt University, this national center disseminates information on evidence-based practices addressing these aims to early childhood programs across the country.

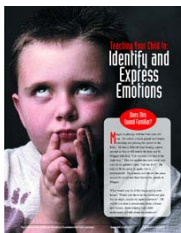
CSEFEL is already well known for its extensive resources for professionals, including its Infant/Toddler and Preschool Training Modules, What Works briefs, and Practical Strategies Materials for teachers and caregivers (including Book Nooks, tools for building relationships, scripted stories for social situations, and tools for developing behavior support plans).

More recently, CSEFEL has created articles designed with parents in mind. The two, four-page articles are titled Teaching Your Child To: Identify and Express Emotions and Teaching Your Child To: Cooperate with Requests. Both documents open with a case-based example of specific challenging behaviors in a section called “Does This Sound Familiar?,” followed by “The Focus,” a one-paragraph description of the theme of the article. The articles emphasize reasonable and age-appropriate expectations, as well as specific strategies designed to address the behaviors.

CSEFEL has also developed a series of six, 1 ½-hour training sessions for parents called Positive Solutions for Families. Although not yet available on the CSEFEL website, each session includes a Power Point presentation, Facilitators’ Script, Workbook Pages, and Activities. All of the sessions take a behavioral approach, where children’s behavior is considered to have meaning. Adults are encouraged to determine the meaning behind the behavior.

Sessions 1 and 2 (Making a Connection! and Making it Happen!) focus on the bottom two levels of the CSEFEL pyramid, nurturing and responsive relationships, and high quality environments. Sessions 2, 3, 4 and 5 (Making it Happen!, Why Do Children Do What They Do?, Teach Me What to Do!, and Facing the Challenge, Part 1) focus on the third level of the pyramid, targeted social emotional supports. The apex of the pyramid, intensive intervention, is covered in sessions 3, 5 and 6 (Why Do Children Do What They Do? and Facing the Challenge, Parts 1 and 2).

Stay tuned to the CSEFEL website for the introduction of these new sessions. All materials on the site are available free of charge. 



Teaching Your Child To: Identify and Express Emotions

(4 pages) PDF



Teaching Your Child To: Cooperate with Requests

(4 pages) PDF

Tips for Encouraging Your Child: Powerful Parenting Practice!

- Tip 1 Get your child’s attention.
- Tip 2 Use behavior specific language.
- Tip 3 Keep it simple – Avoid combining encouragement with criticism.
- Tip 4 Encourage with enthusiasm.
- Tip 5 Double the impact with physical warmth.
- Tip 6 Use positive comments and encouragement with your child in front of others.

PARENT RECOMMENDATION

Parent Recommendation: *Play to Talk*

-Amy Michaletz, mother of five children

Our son Nate was in the Birth to 3 Program through Waupaca County. We started to use the program when Nate was two years old and worked with speech therapy and some occupational therapy. Nate was in the Birth to 3 Program for language and other delays that we have since found out are due to Celiac disease. He really enjoyed spending time with the people from Birth to 3.

One resource that has been fantastic with our late talker is a book called *Play to Talk* by Dr. James D. MacDonald [and Pam Stoika Ph.D.]. Through implementing ideas from this book, we have seen great changes in our son's ability to communicate. The book is very easy to read and has wonderful suggestions for things to try at home. We have been empowered by the ideas in this book and have been able to use many everyday activities as opportunities to see our son blossom.

Dr. Jim opened our eyes up to many things that we were doing that overwhelmed our little guy—asking way too many questions, not waiting for him to communicate and not matching his actions and words. Dr. Jim feels that we as parents have the ability to foster communication not just language, many times throughout the day. His ideas help you to get into your child's world and promote communication. Dr. Jim also has a neat DVD called *Shortcuts* which really helped us to “see” what to do. 🌀



Autumn

by T. E. Hulme (Thomas Ernest Hulme)

Courtesy of the Poetry Foundation <http://www.poetryfoundation.org/>

A touch of cold in the Autumn night—
I walked abroad,
And saw the ruddy moon lean over a hedge
Like a red-faced farmer.
I did not stop to speak, but nodded,
And round about were the wistful stars
With white faces like town children.

Play To Talk: A Practical Guide to Help Your Late-Talking Child Join the Conversation by James MacDonald Ph.D. and Pam Stoika Ph.D.

About the Authors (from the site <http://www.playtotalk.com/PlayToTalk/>):

James MacDonald is Professor Emeritus in Speech and Language Pathology and Developmental Disabilities at Ohio State University. He currently directs the Communicating Partners Center in Columbus, OH and provides consultative services to parents and professionals all over the world. For more information, you can visit his website at www.jamesdmacdonald.org.

Pam Stoika is a developmental psychologist in Madison, WI, specializing in the areas of autism, sensory integration, and social-communicative delays. She has spent almost a decade training parents, professional, and paraprofessionals to be more developmentally effective partners with children. She is also the mother of a 14 year old son with autism.

LEAD POISONING

Childhood Lead Poisoning Still Exists in Wisconsin; What Can You Do?

-Meredith Lins, Wisconsin Childhood Lead Poisoning Prevention Program Nurse Consultant, Bureau of Environmental & Occupational Health, Wisconsin Department of Health Services

Information about Lead Poisoning

Since lead was banned from paint in 1978 and from gasoline in 1980 in the U.S., many people are surprised that lead poisoning still exists. In Wisconsin more than 40,000 children have been poisoned since 1996. Children have been found to be poisoned in every county in Wisconsin. The rate of lead poisoning in Wisconsin is more than double the national average and Wisconsin ranks in the top ten states for number of children lead poisoned in the nation.

Wisconsin has an abundance of older neighborhoods and old housing built during the industrial boom that started in the mid-1800s. Many Wisconsin families with young children live in such neighborhoods, in older homes that have lead-based paint hazards. Virtually all homes built before 1950 have lead-based paint, as do many built since 1950. Paint chips and dust from lead-based paint and varnish form on walls, ceilings and windows. Chipping and peeling paint is the most common cause of lead poisoning in Wisconsin.

A child is considered at risk if the child lives in a home or regularly visits a relative or daycare in a home built before 1950, or lives in or visits a home built before 1978 with recent renovation or remodeling. Children are also considered at risk if they have a sibling who was lead poisoned or if the child is eligible for Medicaid or WIC services. Children from low income families in Wisconsin are at greater risk for lead poisoning, largely because they have limited options for selecting housing.

Lead ingested by mouth is the most common way that children are poisoned. Chipping and peeling lead paint creates dust on windows, floors and porches which can get on children's hands and into their mouths. A few children in Wisconsin have been poisoned by items such as keys, home remedies, pottery dishes, and imported products. Recently lead in toys has gained a lot of publicity. This can be a serious threat if the child is already lead poisoned and plays with these toys often or puts the toys into his or her mouth. However, in Wisconsin children are usually lead poisoned from the chipping and peeling paint in old homes.

Children under age six are at greatest risk because they frequently put their hands and other objects into their mouths which increase the chance of getting lead into their body. In Wisconsin, the highest rate of children found to be lead poisoned occurs at age two, with only slightly lower rates at ages one and three.

Effects of Lead Poisoning

There is no safe level of lead in the body; even very low levels of lead exposure can cause permanent brain damage and negatively affect health throughout a child's life. Children under age six are particularly vulnerable to the effects of lead because their brain is developing so rapidly. Lead can affect the child's brain and disrupt the normal development of the child's emotional response, memory, learning, timed reactions and/or hearing loss and auditory processing disorders. The result may be a lowered IQ, learning disabilities, language development problems, attention problems and developmental delays, coordination problems, autistic-like symptoms, Aspergers-like symptoms, sensory integration disorders, seizures, and in some cases, death.

Lead poisoning can result in the child having problems at school due to disruptive behaviors, aggression and hyperactivity. Childhood lead poisoning is associated with higher rates of high school dropout, juvenile delinquency and teenage pregnancy. Research shows that violent crimes committed as an adult are associated with childhood lead poisoning. Lead poisoning may have long term health effects when the child becomes an adult by increasing the risk of death from stroke and heart attacks, kidney disease, diabetes, cognitive deficits such as memory loss and Alzheimer's disease.

A child with lead poisoning may not show any symptoms of being poisoned; therefore, parents may have no idea that lead is disrupting the child's brain, nervous system and organs. If a child is lead poisoned, the child may have no symptoms initially, but then may show more noticeable effects when the child is in school. Critical transition points in the child's life, when children may display difficulties due to lead poisoning, are first grade, fourth grade, and sixth or seventh grade.

LEAD POISONING

Determining a Diagnosis of Lead Poisoning

The only way to know for sure if a child is lead poisoned is through a blood test. When a capillary (finger stick) test result is greater than or equal to 10 micrograms per deciliter (mcg/dL), a blood sample drawn from the vein is required to confirm that the child is in fact poisoned. All children enrolled in Medicaid are required to be tested at ages 1 and again at age 2. Children, who are not tested prior to age 3, must be tested at least once between ages 3 to 5.

If a child's test result indicates the child is lead poisoned, a physician may want to order an "erythrocyte protoporphyrin (EP)" test each time the blood test is drawn. This test is valuable because it indicates how much lead is actually in the body and if the child was recently poisoned or if he or she has been poisoned over a longer period of time. Each time the blood is drawn to monitor the child's blood lead level; the same blood sample can also be used for the EP test. Lead can be absorbed into the blood, soft tissue and bone. By continuing to perform follow-up lead tests to monitor the child's lead level, the appropriate interventions can be determined for the child and the family so that the level of lead in the blood decreases as rapidly as possible.

Recommended Interventions

A child is considered lead poisoned if the blood lead level is equal to or greater than 10mcg/dL. The local health department will contact families who have a child with a level of 10mcg/dl or greater. They may schedule a home visit with the family and an environmental investigation to discuss lead poisoning, determine the source of the poisoning and recommend safety measures that can be taken in the home. Their focus is on reducing the child's exposure to lead. The clinic physician or nurse may contact the family to discuss when follow-up blood tests are due.

A child with a venous blood lead level of 20 mcg/dL or more or 2 venous blood lead levels of 15 mcg/dL or more (drawn at least 90 days apart) is considered by Wisconsin statute to have an "elevated blood lead level." Wisconsin State Statute 254 requires that an environmental investigation shall be performed on homes with children under age 6 who have an elevated blood lead level. These families are contacted by a public health nurse and a lead hazard investigation is conducted by a certified lead risk assessor. After the investigation the homeowner is notified of any lead hazards that were found and methods to correct the hazards to make the home lead-safe. If the family lives in a rental property, the landlord is responsible for making the necessary repairs.

The public health nurse assesses resources that may be helpful for the family and child and coordinates referrals for the family and child, such as Birth to 3, WIC, a nutritionist, etc. A nutritional evaluation can indicate if the child is getting enough calcium, iron and vitamins into their diet. A developmental screening needs to be done to serve as a baseline for future screenings. Educators such as Early Childhood, Head Start, or therapists in Birth to 3 may be included to help the child with language or learning needs. Referrals for financial assistance or finding alternate housing may be necessary. The physician will oversee the lead testing and monitor the results, also making the necessary referrals.

Families often feel overwhelmed and describe feelings of fear, guilt, uncertainty, and loss of control. Often they are faced with housing and financial concerns. All of a sudden, the family is dealing with a variety of "specialists," such as medical, public health, contractors, educators, child development specialists, bankers, insurance, and extra paperwork. For example, will this family need to move out of their home temporarily? Do windows need to be replaced? Is a landlord involved?

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LEAD POISONING

The Role that Home Visitors and Parents of Children Ages Birth to 6 Can Play



Parents who live in a home built before 1950 or who have renovated a home built before 1978, or if their child spends time in such a home, should be sure that their child receives a blood lead test. Home visitors seeing a child with developmental delays can assess the possibility of lead poisoning. Three important questions can be asked: (1) has the child been tested for lead, (2) when was the house built and (3) what is the condition of the paint in the home. If the child has not been tested, lives in a home built before 1950, or deteriorating paint or varnish are present (See Figure 1), the home visitor should recommend the child be tested as soon as possible. The home visitor should also assess if the home is near heavy traffic or industrial areas, if a household member is involved in a lead-related occupation or hobby or if any vinyl vertical or mini blinds are present (children have been lead poisoned from some vinyl blinds).

The goal is for the child and family to receive the appropriate support and assistance they need in order for the child's blood lead level to decrease, prevent further lead poisoning, have the opportunity to be monitored for delays and receive the interventions as soon as possible. ☺



[The Legacy of Lead - Full Report](#)

[The Legacy of Lead - Summary](#)

Factors Related to the Scope of Early Intervention Service Coordinator Practices

Mary Beth Bruder, PhD; Carl J. Dunst, PhD
Infants and Young Children, July-September 2008, 21:3, 176-185.
Summary by Arianna Keil, WPDP

Link to full text article
http://depts.washington.edu/isei/iyc/21.3_brunder.pdf

A recent study published in the journal *Infants and Young Children* used a parent-completed survey to examine the relationship between multiple Part C service coordinator (SC) variables as well as child/parent variables and different SC practices. Authors Bruder and Dunst analyzed 346 surveys returned from parents of children enrolled in Part C early intervention (EI) programs in 46 states across the country.

SC practices assessed included Individual Family Service Plan (IFSP) development and oversight, oversight and monitoring of EI service provision, coordination and provision of EI services, family participation and decision making regarding IFSPs and service provision, provision of information to families about EI and related services, provision of information to families about child learning opportunities, planning for and assistance with the transition from EI to preschool services, information about and assistance in obtaining child healthcare, and information about and assistance in obtaining child care. These 9 practices were divided into 3 different categories: practices having to do with EI services, non-EI services/community resources, and transition planning.

These 3 practice categories were then compared with various SC and child/parent variables. SC variables included 3 SC models: the dedicated model (agency providing SC is independent from service provision) versus the intra-agency model (SC provides only SC but works for the same agency providing EI services) versus the blended model (SC provides both SC and EI services).

Researchers assessed how often SCs had contact with families, how often SCs had contact with EI program staff or providers, and how long SCs had been working with each family. Lastly, both relational and participatory family-centered helping practices among SCs were examined. Relational practices included compassion, active listening, empathy, and strength-based considerations. Participatory practices included behaviors involving family member's choices and decision-making, and various methods to enable family competence and capacity.

Child factors included age and EI eligibility according to established disability or developmental delay/at risk. Parent factors included respondent age, education, marital status, employment status and ethnicity. 93% of respondents were mothers, 2% were fathers, and the remaining 5% included foster parents, grandparents and other family members.

Results indicated that SC variables were more likely to be correlated with SC practice measured as compared with child/parent variables. The single child/parent variable significantly correlated with SC practices was respondent education. Respondents completing more years of formal schooling indicated that SC engaged in fewer practices related to community resources and EI services.

continued on page 11

Preserving Early Childhood Conference

March 11-12, 2009

Radisson Paper Valley, Appleton

Travel-in Tours March 10, 2009

<http://www.collaboratingpartners.com/>




JOURNAL HIGHLIGHTS

In contrast, nearly all of the SC measures were significantly correlated with practice measures. Family-centered practice measures accounted for the largest amount of variance in service coordination practice. Both helping practices were related to the SC practice scores, with family-centered participatory helping having the strongest association with SC practices.

In addition, respondents receiving blended SC reported greater SC use of practices as compared with the dedicated SC model. The authors suggest that dedicated SCs often have larger caseloads, resulting in less time spent per family.

Three key points:

1. Family-centered helping, particularly helping that families participate in and that boost their capacity, is one of the essential roles of service coordinators.
2. Blended models of service coordination, in which SC provide both coordination of services and some of the services as well, may result in more SC overall as compared with other models such as dedicated models.
3. Highly educated families often receive less support on EI services and community resources as compared with less educated families. More educated families frequently need this support and information as well. 



“The strength of association between family-centered participatory helping] illustrates that how service coordinators work with families matter a great deal in explaining variations in use of desired and valued practices...The use of family-centered practices has both direct and indirect influences on the nature of the parent-practitioner relationships and the child, parent and family outcomes.”

Head Start: Investing in Excellence

7th Annual Wisconsin Head Start Association Training Conference

February 2-4, 2009

Kalahari Waterpark Resort & Convention Center, Wisconsin Dells

Contact information: Molly at 608-442-6879 or kovarik@whsaonline.org



DEC HIGHLIGHTS

Jenny Lange Scholarship Fully Funded

-Mary Joslin, CESA 10

The Wisconsin Division for Early Childhood (WDEC) is pleased to announce that the Jenny Lange Scholarship at UW Whitewater is fully funded to award one \$500 scholarship each year from now on. Any additional funds that are raised will be used to increase the scholarship amount or the number of scholarships in Jenny's honor. Thanks to all who worked to honor Jenny and the work that she has done in Wisconsin. Additional donations can be made out to University of Wisconsin-Whitewater Foundation. In the memo line please write Jenny Lange Scholarship. Please mail the donation to:

Randall G. Upton
Director of Advancement
College of Education
University of Wisconsin-Whitewater
800 West Main Street
Whitewater, WI 53190-1790 



Circles of Life Conference

April 30- May 1, 2009
Marriott Madison West, Madison.

<http://www.wfv.org/circle/>

DEC•2008

24th Annual International Conference on Young Children with Special Needs & Their Families

October 27-30, 2008
Minneapolis, Minnesota

<http://www.dec-sped.org/conference/>

**The Division for Early Childhood**

GIVING IT AWAY

Giving it Away: Adult Learning Strategies

-Arianna Keil, WPDP

Most early interventionists and early childhood special educators are trained to work directly with children. Research tells us, however, that intervention is most effective if the child's primary caregivers embed therapeutic and educational activities throughout the day, in everyday life. Many EI and ECSE professionals do not feel adequately prepared to work with and educate parents.

Malcolm Knowles is an adult learning strategist who has published literature on this topic. His work focuses on five specific strategies designed to facilitate adult education.



1. Agree on learning priorities and roles

Here's where skills in negotiation are helpful. Your ideas as an interventionist as to what activities should receive the greatest attention may differ from the parents' priorities. Parents count on professionals to offer their recommendations, but they also count on us to listen to and value their opinions. Try to find a middle ground and establish jointly what is most important.

2. Join in rather than take over

Easier said than done! Early interventionists tend to be hands-on types of people. Stepping back (literally and figuratively) and allowing the parent to practice the skills you have just demonstrated is essential to their learning. Allow the parent to be a bit "clumsy" in their efforts at first, and praise even the smallest efforts in the right direction. We do this all the time with kids – why not try it with their parents?

3. Build on the caregiver's strengths

Most interventionists are superb at emphasizing strengths. Determine what they are for each parent – her ability to engage her daughter, his willingness to make funny faces and make his son laugh – and capitalize on them. Tell the parent what they are doing well and try to fit intervention strategies within these naturally occurring gifts.

4. The relationship does matter

Relationship-based early interventionists focus on two relationships: the parent-child relationship and the parent-professional relationship. Relationships between parents and their children clearly influence many aspects of child development. In addition, trusting relationships between interventionists and parents increase the likelihood that strategies demonstrated on home visits will be implemented in the therapist or educator's absence.

5. Provide specific and meaningful feedback to enhance competence

Undoubtedly there will be times when a parent is not implementing an intervention strategy correctly. Try to offer feedback in these cases that is not only very specific (i.e., "It may work better if you place your hand here,") but is nonjudgmental as well. When parents are doing something correctly, let them know! It can be intimidating to learn a new skill in front of a seasoned professional.

As compared with working with children, working with adults is based more on partnership and shared beliefs. The next time you have the opportunity to work with a parent and teach her a new activity to benefit her child, be intentional about incorporating one or more of these strategies into your approach and watch your efforts grow! 🌱

References:

Knowles, M. S. (1995). *Designs for adult learning*. Alexandria, VA: American Society for Training and Development.

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JOB POSTINGS

Rehab Resources, Inc., a leading provider of pediatric therapy services in Wisconsin is seeking speech pathologists to work in our Birth to 3 programs. Work with a team of teachers, occupational therapists, physical therapists and other speech pathologists. New graduates welcome to apply. On-site CFY supervision is available at all sites. Generous benefits and use of laptop provided for documentation. Flexible work week.

Full Time Positions:

Sheboygan County B-3 office located in Sheboygan. Treat children 0-3 and pediatric out patients.

Jefferson County B-3 office located in Jefferson. Treat children 0-3.

Brown County B-3 office located in Green Bay at ASPIRO, Inc. Work with a strong interdisciplinary team. Caseload included 0-3 and over 3 children.

Washington County B-3 office located in West Bend. Treat children 0-3 and pediatric outpatients.

For more information please contact Jan Stevens 920-885-4750 or send email resume' to jstevens@rehabresourcesinc.net Fax: to 920-885-3839

Visit our website for additional information about Rehab Resources, Inc. www.rehabresourcesinc.com

Cerebral Palsy, Inc. in Green Bay, WI is seeking a full-time or part-time **Occupational Therapist**. Duties include serving children in **Birth to 3 in Brown County** which involves travel to home and community sites. In addition, this position will also provide center-based services for pediatric clients age 3 and older.

Qualified candidates will have a Bachelor's degree from an accredited OT program and be licensed or eligible for licensure in the State of Wisconsin. Applicants with experience serving children with developmental delays or disabilities are desired. New graduates are strongly encouraged to apply. Must hold a valid Wisconsin driver's license. We offer a competitive salary and an excellent benefit package.

Cerebral Palsy, Inc. in Green Bay, WI is seeking a full-time or part-time **Speech Language Pathologist**. Duties include serving children in **Birth to 3 in Brown County** which involves travel to home and community sites. In addition, this position will also provide center-based services for pediatric clients age 3 and older.

Qualified candidates will have a Master of Science Degree in speech and language pathology or communication disorders and be licensed or eligible for licensure in the State of Wisconsin. Applicants with experience serving children with developmental delays or disabilities are desired. New graduates are strongly encouraged to apply. Must hold a valid Wisconsin driver's license. We offer a competitive salary and an excellent benefit package.

Job descriptions and applications are available at www.cp-center.org. Please send cover letter and resume to:

Cerebral Palsy, Inc.

Attn: Human Resources

2801 S. Webster Ave.

Green Bay, WI 54301

Or email to: Jkozicke@cp-center.org

Birth to **6** EVENTS



Waisman Center

Wisconsin Personnel Development Project

Editor: Arianna Keil, WPDP

Contributors: T. E. Hulme, poet
Mary Joslin, CESA 10
Arianna Keil, WPDP
Meredith Lins, Department of Health Services
Amy Michaletz, parent
Kris Pizur-Barnekow, Univ. of IL - Chicago
Jennifer Runquist, UW-Milwaukee

Desktop Publishing: Cheri Sanders, WPDP

Copy Editor: Lynn Sankey, WPDP

Director: Linda Tuchman

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For additional information, call 608-890-0144, 1-800-532-3321, or email keil@waisman.wisc.edu

Deadline for submissions to next Birth to 6 EVENTS: February 27, 2009.