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Strengthening Relationship-Based Practice in Early Intervention: A Field-Tested Professional Development Model

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Connected Beginnings Training Institute

23rd National Training Institute (NTI)
Friday, December 5, 2008

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Introduction

- Research supports the importance of relationships for infant-toddler development.

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QuickTime™ and a
decompressor
are needed to see this picture.

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What Supports Moving from Research to Practice?

- Professional development
- Supervision and mentoring
- Systems support

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The National Perspective

- Original provisions of the Education for all Handicapped Children Act Amendments of 1986 Mandated services to address social and emotional challenges as well as problems in language, cognition and motor development.
- *Staff development in social and emotional development is not a new directive…but delayed implementation* (Center for the Development Child at Harvard University, 2007).

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National OSEP Mandate 2006

- Summary of children's progress (Part C and B):
  - Positive social-emotional skills
    - Social relationships
  - Use of appropriate behaviors to meet one's own needs
    - Self regulation
- Focus on how skills are used in every day experiences

(20 U.S.C. 1416(a)(3)(a))

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Early Intervention (EI) in Massachusetts

- **Broad eligibility criteria**
- Established delay or disability
- Environmental and biological risk
- **Implementing CAPTA by referrals from Department of Children and Families to EI.**

http://www.mass.gov/dph/fch/ei.htm

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MA Inter-agency Coordinating Council

- In the Fall of 2008, unanimously approved a Vision Statement and Draft Recommendations to present to the MA Department of Public Health affirming the importance of training and support for EI practitioners to integrate a relationship-based approach to practice supported by professional development and reflective supervision.

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ICC Vision Statement

- *The MA EI system supports each child and family's social and emotional well-being and assists in achieving positive development in all children by recognizing and promoting children's earliest relationships within the context of their family, community, and culture. The system addresses the mental health of all children enrolled in EI using a consistent and universal approach to screen and support children and families.*

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What is Infant Mental Health?

- The developing capacity of a child from birth to three to:
  - Experience
  - Regulate
  - Form close and secure relationships
  - Explore the environment and learn
- All in the context of family, community, and culture (ZTT, 2001)

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From the Point of View of the Baby

- There are no disciplines
- Infant Mental Health (IMH) and Early Intervention-working together-remaining distinct
- Dynamics of relationships brings us together

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What is an IMH Intervention Perspective?

- Keeps in mind the experiences of baby and caregiver(s) in their social network
- Considers the influence of relationships on relationships
- Keeps relationship dynamics in mind while looking at strengths and challenges in development in all domains

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What is the IMH Core Knowledge Base?

- With attention to family and community culture, focuses on identifying and expanding adaptive processes in daily exchanges and routines to enhance the experience of both baby and caregiver through attention to:
  - Emotional regulation.
  - Exchanges of communication signals.
  - Consistency over time.
  - Process of connection-disconnection-repair.

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How EI Integrates IMH Principles across Disciplines: Best Practice

- Focusing on dynamics of relationships
- Routinely talking about and assessing social and emotional development of infants and toddlers
- Identifying emotional challenges faced by parents and other significant caregivers
- Supporting practitioners in the emotions evoked in the work through reflective supervision (individual and peer) and professional development
- Providing consultation to child care centers around individual child
- Providing consultation to child care programs and centers (next step)

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IN-TIME Infant Mental Health (IMH) Curriculum Core Goals

- Affirm and enhance an infant mental health perspective in EI
- Increase knowledge of current IMH research and practice
- Increase confidence in IMH *therapeutic* intervention

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Emotional Development Involves a Complex System

- The EI practitioner becomes an important element in that system.

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The Level of Observable Behavior

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The Level of Observable Behavior

Adding the Level of Internal Experience . . .

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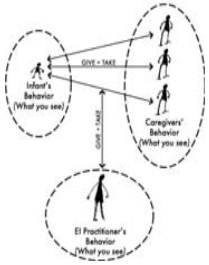
The Level of Observable Behavior



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Description of IN-TIME Curriculum Content

- Content draws from research and practice
  - Introduction and framework for Infant Mental Health (3 hours)
  - What infants and toddlers bring to relationships (9 hours)
  - What parents and caregivers bring to relationships with infants and toddlers (6 hours)
  - Understanding and Supporting the Give and Take between Infants-Toddlers, their Parents and other Significant Caregivers (12 hours)

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IN-TIME Curriculum Process

- Team building-warm-up exercises
- Reflecting on beliefs and values
- Reading and seeing videos of research and practice
- Practicing observation with video clips
- Doing role plays
- Working from strengths in observing and intervening
- Integrating screening and assessment tools

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IN-TIME Curriculum Structure

- The participants:
  - Director and/or
  - Supervisor/team leader
  - Direct service staff
- Format
  - 30 Hours of Training
  - 6 Hours of On-Site group case consultation

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Two-part Study of Effectiveness of IN-TIME Training

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Study - Parts I and II

- Part I: based on pre-post data during IN-TIME training
- Part II: based on data from follow-up surveys completed 1-4 years after IN-TIME training completed

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Part I Questions for Evaluation of Training

- To what extent does participating in IN-TIME increase participants' perceived knowledge of IMH?
- To what extent does participating in IN-TIME increase participants' confidence in intervening to support IMH?

Part I Methods

- 3 cohorts (n=75), 2004, 2006, 2007
- Pre-post questionnaires
- Closed-ended scaled questions covering knowledge (2 cohorts) and confidence (3 cohorts)
- 2004 t-test used to look for differences between pre- and post-training in reported confidence
- 2006, 2007 repeated measures ANOVA used to test for pre-post differences in knowledge and confidence as well as differences between the cohorts

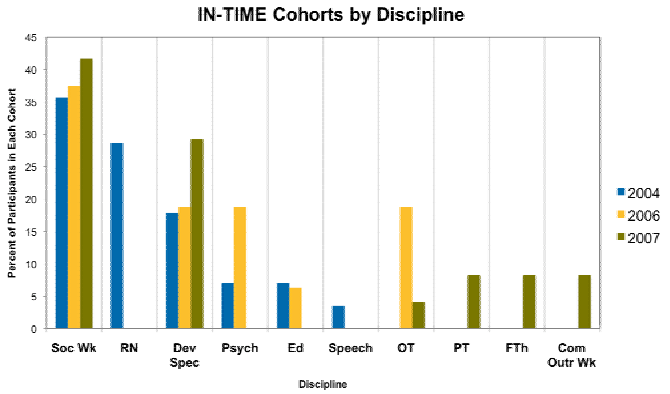
Part I Participants by Title/Role

- 75 participants in three (3) IN-TIME cohorts (2004, 2006, 2007), 63 completed surveys
- Role/Position:*

	Springfield %*	Boston %	Lowell %
Program Director	10.7	11.8	16.7
Clinical Supervisor/Team Leader	17.9	35.3	33.3
Other EI Staff Member	71.4	52.9	50.0

* 2004 cohort role/position, n=28 and is derived from participant attendance information. In 2004, role information was not asked on participant survey.

Part I Participants by Discipline



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Part 1 Findings

"How helpful has the information gained in IN-TIME been in my work? I use it every day!"

- IN-TIME Follow-up Study Participant

Part I Knowledge Findings

- Statistically significant increases in all six knowledge areas:
  - IMH perspective
  - Interaction between the developing brain and the environment
  - Social and emotional development of infants and toddlers
  - Infant and adult temperament
  - Social-emotional screening tools for infants and toddlers
  - Maternal/caregiver depression and other disorders that may affect adult emotional well-being

Part I Other Knowledge Findings

- No significant relationship between years of experience (in EI practice) and change in perceived knowledge
- Only one difference between cohorts: 2007 cohort started with lower perceived knowledge of brain development and had a larger increase than 2006 cohort

Part I Confidence Findings

- Significant increases in participants' "confidence in intervening to support IMH"
- No significant relationship between years of experience (in EI practice) and change in confidence
- No significant differences between cohorts

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Part II Questions for Evaluation of Implementation in Practice

- Are participants integrating an IMH perspective in their work, post IN-TIME training?
- What facilitators and challenges are associated with integrating an IMH perspective into Early Intervention practice?

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Part II Methods

- Follow-up survey by phone and e-mail in 2008 using both closed and open-ended questions (n=12)
- Selection criteria:
  - Include all three cohorts (Springfield, Boston, Lowell)
  - Only programs with at least two IN-TIME participants still employed by program

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Part II Methods

- Sampling frame: 10 EI programs, 32 participants
- Final sample: 5 EI programs, 12 participants
- Analysis using standard qualitative methods – including identifying themes and frequency of appearance

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Part II Participants

- Twelve participants
- Mean of 14 years EI experience (range 5-26 years)

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Part II Participants

- Participant role or position (more than one role/position allowed):

Answer Options	Response Percent	Response Frequency
Program Director	15%	2
Assistant Director	0%	0
Clinical Supervisor	30%	4
Team Leader	15%	2
Direct Care Provider/Clinician	54%	7
Other	15%	2

Part II Findings

Part II: Quantitative Findings- Perceived Impact on Clients and Practice

Yes/No Questions	% Yes
Did IN-TIME training have an impact on your EI practice?	91%
Did IN-TIME training have an impact on your EI program's practices?	91%
Did what you learned in IN-TIME have an impact on your clients?	91%

Perceived Influences on Job Responsibilities

Yes/No Questions	% Yes
Do your formal job responsibilities include observing parent-child interaction?	91%
Do your formal job responsibilities include giving feedback on positive interaction?	91%
Do your formal job responsibilities include helping parents see their skill in understanding their baby/toddler?	91%

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Integration of Skills and IMH Perspective

	Not Helpful	Somewhat Helpful	Helpful	Very Helpful
How helpful has the information or skills you gained in the IN-TIME training and consultation been in your work?	0%	0%	54%	46%
	Not Confident	**Somewhat Confident**	**Confident**	**Very confident**
What best describes your current confidence in intervening to support infant-toddler mental health?	0%	9%	55%	36%
	Unsuccessful	**Somewhat Successful**	**Successful**	**Very Successful**
Overall, how successful would you say you have been in integrating an IMH model into your EI work?	0%	50%	25%	25%
	Not influential	**Somewhat Influential**	**Influential**	**Very influential**
How influential has IN-TIME been to your ability to integrate an IMH model into your EI work?	0%	25%	50%	25%

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Adoption of Reflective Practices

	Daily	Several Times a Week	Weekly	Bi-Weekly	Monthly	Less Than Once a Month	Yearly	Not at all	Other	Total
Reflective Supervision	0	2	2	0	4	1	1	0	0	10
Group Discussion	0	0	4	1	2	1	0	0	0	8
Peer supervision	0	1	2	0	1	2	0	1	1	8
Other	1	0	0	0	0	0	0	0	0	1

"I meditate and pray about my work concerns. I talk with my supervisor often and frequently with other staff members when I am concerned about a family/child."
-IN-TIME Follow-up Study Participant

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Use of Screening Tool(s)

	% Yes	% No
Are you currently using a screening tool(s) to screen infants/toddlers social and emotional well-being?	91%	9%
Are you currently using a screening tool(s) to screen caregivers for depression?	25%	75%

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Use of Screening Tools with Infant & Toddlers

- Agency and/or Program support for screening tool use appears to be an important influence in moving from training to implementation in practice.

"My agency said that everyone is going to do it (use a screening tool to screen infants/toddlers)- we made a programmatic decision to do it and then we had training on the tool." - IN-TIME Follow-up Study Participant

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Use of Screening Tools with Adults

- Respondents who were not utilizing screening tools for caregiver depression said they had "ethical issues", the tool was not "provided" by their program or that staff was unfamiliar or needed more training on the tool.

"We are not routinely screening for caregiver depression because… " I believe there is an ethical issue involved in screening for something when you have no service to offer, if a need is identified."

- IN-TIME Follow-up Study Participant

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Part II Qualitative Findings: Most Often Identified Themes

IN-TIME training:

- Increased understanding of relationships between infants and their parents/caregivers through observation/observational skills and sharing positive (strengths-based) observations of interactions
- Increased use of social-emotional assessment tools
- Increased awareness of the importance of mental health and social-emotional development
- Improved knowledge and understanding of concepts of temperament and goodness of fit
- Increased knowledge and understanding of birth-three brain development
- Underlined the importance of working with team/peers and sharing ideas with coworkers (including reflective practices)

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Facilitators and Barriers Associated with Integrating an IMH Perspective into EI Work

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Facilitators

- Agency and/or program support for training
- Members of a team trained together
- Gives EI practitioners a "common language" to talk with other EI practitioners

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Barriers/Challenges

- Need to train additional EI staff members in assessment tools- takes time, requires that others are comfortable using tool
- Staff turn-over
- Lack of program support

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"Successful and sustainable implementation of evidence-based programs always requires organization and systems change." - Dean Fixen[1]

[1] Fixen, D.L., Blase, K.A., Naoom, S.F., Van Dyke, M. & Wallace, F. (2007). *Implementation: The Missing Link between Research and Practice.* Presentation at 2007 NECTAC Conference, Arlington, VA.

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Questions & Answers

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