IMPLEMENTING COMPONENTS OF THE ROUTINES-BASED MODEL

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Abstract: The MBR is comprised of 17 components that can generally be grouped into practices related to (a) functional assessment and intervention planning (for example, Routines-Based Interview), (b) organization of services (including location and staffing), (c) service delivery to children and families (using a consultative approach with families and teachers, integrated therapy), (d) classroom organization (for example, classroom zones), and (e) supervision and training through checklists. In this model, some practices are more relevant to some stakeholders than are others. Those practices are often the gateway to adoption of the whole model. In addition, some practices are natural first steps, such as the Routines-Based Interview, because implementation of that component leads almost naturally to the implementation of other components. In implementation science, what is being implemented is often described as a single practice or program. We have expanded this concept to plan for implementation of different components in a sequential, not concurrent, process. The session will provide examples of different programs' and countries' implementation plans.

The physicist Edward Teller once said, "A fact is a simple statement that everyone believes. It is innocent, unless found guilty. A hypothesis is a novel suggestion that no one wants to believe. It is guilty, until found effective." The Routines-Based Model, described here, is a hypothesis but, like all good hypotheses, it is built on a foundation of solid reasoning, theory, and evidence. It consists of a set of practices designed to provide children with the best opportunity possible to function, to provide families with the support to foster their children's development, and to remedy some of the mistakes the field has made (see Figure 1).

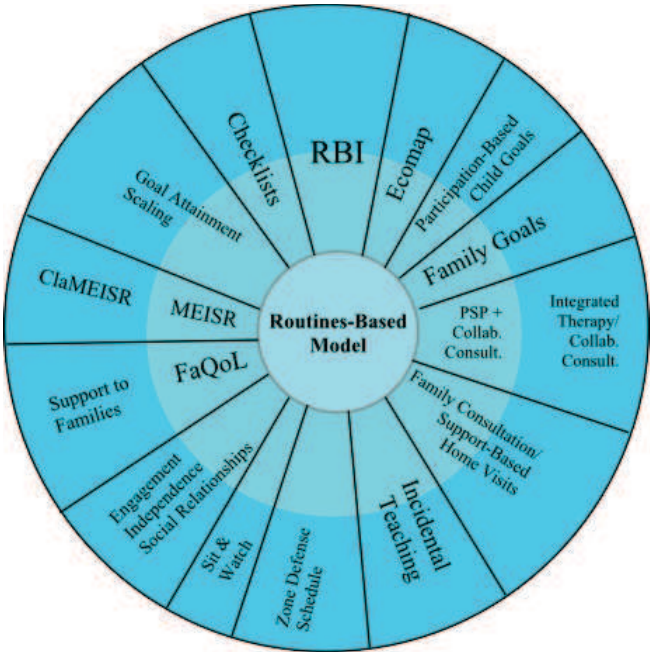

Figure 1. Components of the Routines-Based Model

One of the foundations of the model is an emphasis on function and participation by children. For example, all child goals are written in terms of the routines in which the child will participate, as a result of being able to perform the skill. Indeed, it is the parents' desire for more meaningful participation in the routine that leads to their choosing those goals in the first place. Yes, parents choose the goals, as will be described later. Participation in young children with disabilities means they are engaged in the routine, with engagement defined as the amount of time the child spends interacting with adults, other children, or materials in a developmentally and contextually appropriate manner at different levels of competence (Bernheimer & Weisner,2007; McWilliam & Bailey, 1992; Weisner, 1997). Engagement, along with its

subdomains, independence and social relationships, are the core outcomes addressed in the Routines-Based Model. Together, these three constitute the behaviors adding up to participation in routines. A *routine* is defined as an events, time of day, or activity that occurs most days; it does not mean a set procedure or solely a caregiving activity like diaper change. Therefore, all families have routines, even if those routines are unpredictable in their order and form. In psychoanthropological terms, families orchestrate their daily routines within their ecological niche.

A second foundation of the model is working with families more than children, with the understanding that they have the opportunity, between our visits, to teach children. And we professionals really do not have that opportunity, in 1 to 5 hours a week. If the children were older, perhaps this tutoring might work, but not for children under the age of 6. Furthermore, parents or those in loco parentis are still the major influence on children's learning, whether because of increased opportunity or other, more relationship-like reasons. Still further, respecting the family is simply the right thing to do, so our supports should build on families' desires for how they want their family routines to go. Our ethical obligation is to provide information to help families make decisions (like how they want their routines to go), but it is well known that the laws of homeostasis are powerful when it comes to family routines (Weisner, Matheson, Coots, & Bernheimer, 2005). Families will not stray far from the ecocultural niches they have developed, so early intervention must be in the business of tweaking routines, not reforming them. An important part of family-centered practice is ensuring the primary caregiver's wellbeing is part of the support we provide, on the principle that she can fill her child's bucket only to the extent that her own bucket is filled. Finally, because adults can benefit from

consultation once a week, whereas children do not learn in weekly sessions, the emphasis of the early intervention visit needs to be on building parents' capacity.

The third foundation of the model is to remedy some of the mistakes professionals have been making in early intervention. McWilliam (2011) identified the top 10 mistakes:

1. Doing all the talking at intake visits,
2. Asking families about daily routines at every meeting leading up to plan development,
3. Basing goals only on what parents say they want,
4. Ignoring the participation purpose of child-level goals and skimping on measurability of goals,
5. Matching services to deficits,
6. Working directly with the child on home visits,
7. Modeling or demonstrating blindly,
8. Using the same home visiting approach for all families,
9. Focusing exclusively on the child's well-being and quality of life, and
10. Working only with children in classrooms.

Model

The Routines-Based Model is a marriage of what have been called the Routines-Based Early Intervention Model (McWilliam, 2010) and the Engagement Classroom Model (McWilliam & Casey, 2008). It is fairly comprehensive, covering functional assessment and intervention planning, organization of services, service delivery to children and families, classroom organization, and supervision and training through checklists.

Functional assessment and intervention planning

Functional assessment is the determination of a child's competence and participation in everyday routines. It differs from most assessment conducted in early intervention, which is usually done to establish eligibility and, highly erroneously, to develop intervention goals. Intervention planning is the selection of goals—the specifics of what early intervention will address. In the RBM, the components in this area are the Routines-Based Interview (RBI) (McWilliam, Casey, & Sims, 2009), the ecomap (Campbell & Sawyer, 2007; Jung, 2010), and participation-based goals (Campbell & Sawyer, 2007). The RBI is the best known component of the model, and it involves professionals' asking in-depth questions of families about child and family functioning in everyday activities and events, as preparation for families to identify their goals. All families, in the hands of a skilled interviewer, can identify 10-12 goals. These goals are for the child or for the parents. Family-level goals can be related to the child or not.

Organization of Services

Services are the supports professionals provide to families and teachers of children in classroom or group care settings. The RBM component in this area is the primary service provider, although other relevant features of the model are the use of natural environments and the frequency of visits. The primary service provider (PSP) is one early intervention professional from any discipline who is the main support to the family (Shelden & Rush, 2013). That professional is in turn supported by other professionals who make joint home visits with the PSP. In the U.S., locating services in the home or community is not a question, other than, in some states, for therapy services. The early intervention law mandates the use of natural environments to the maximum extent

possible ("Individuals With Disabilities Education Act," 2004). In other parts of the world, early intervention is still predominantly clinic based. As professionals become more family centered and routines based, they soon understand the value of working with families in the same places where the families "intervene" with their children. When plans have 10-12 goals, it is hardly surprising that weekly visits are recommended. Furthermore, between our visits, families are implementing strategies that might not work. They can't go too long before needing more consultation.

Service delivery to children and families

Once services are organized, they are provided, in the U.S., through home visits or child care visits for children under 3 and through classroom programs or visits for children 3-5. In other parts of the world without the unfortunate age-3 transition policy, the age-by-setting distinction isn't nearly as clear. The hallmark feature of the RBM in service delivery is supporting adults who spend time with children rather than providing hands-on services to children. Professionals still need to have deep knowledge about child development, interventions, and disabilities, so their work with adults is on point. Three of the RBM components addressing service delivery are family consultation, collaborative consultation to child care, and integrated therapy. Family consultation means using a collaborative approach with families, employing principles of adult learning theory. Professionals support the family to make decisions, to provide information about child and family functioning, to think through solutions (i.e., interventions), to carry out interventions between professionals' visits, and to monitor child progress. Although these responsibilities seem numerous, family consultation is also about fitting our work into families' preferences and routines, not about adding to their

stress. Collaborative consultation with child care programs similarly is built on joint solution finding and building the capacity of the child care teachers to meet the child's needs during all those hours between early intervention visits. Integrated therapy is conducted by using an approach called *individualized within routines* (McWilliam, 1996), (Aguiar & McWilliam, 2013; McWilliam, Trivette, & Dunst, 1985)in which the specialist joins the child in a regular classroom activity and weaves intervention into that play scheme, so the teaching staff can see how this integration occurs. It should be used as part of broader collaborative consultation, so more macro-level needs, such as classroom management, are also addressed.

Classroom organization

Our longstanding interest in child engagement (Aguiar & McWilliam, 2013; McWilliam et al., 1985) has included engagement in classroom settings. Our research in this area (Casey, McWilliam, & Sims, 2012) has led to the development of a model of classroom management described in the book *Engagement of Every Child in the Preschool Classroom* (McWilliam & Casey, 2008). Key components of the *engagement classroom model* (ECM) are functional goals derived from a Routines-Based Interview, incidental teaching, integrated therapy, zone defense schedule, *sit and watch* (for behavior management), and data collection. In recent years, we have recommended implementing the ECM in a Reggio Emilia-inspired approach, to encourage routines focusing on play, discovery, and creativity; to encourage the project approach (Helm & Katz, 2011); and to encourage engaging and beautiful environments.

Supervision and training through checklists

A wise person once said, "You can't expect people to do something if you don't tell them to do it." Checklists (a) specify the steps of a practice, (b) provide a vehicle for observational feedback on performance, and (c) provide implementation fidelity data. The most challenging aspect of checklist training is finding coaches to provide checklist-based feedback. Many early intervention programs do not have enough staff members for effective performance-based feedback. Checklists can also be used by peers (e.g., coworkers) or even for self-checks. But the best use of them is by a knowledgeable professional who uses them to observe and give feedback. Feedback is a whole topic unto itself, when one considers the timing (right after or right before the session), the format (oral, written), the style (punitive, supportive), the intervals (weekly, quarterly), and the amount (one or two points, everything observed).

The model has been successfully implemented in a number of states and countries, and the process of implementation is described in Tânia Boavida's paper in the proceedings for this conference. In the next section, we discuss in particular how the components are linked logically, which can influence the order of implementation.

Component Links for Implementation

An intervention model has a number of components; otherwise, it would be simply a practice. Although consumers might be tempted to implement the whole model at once, in reality this would be too big a task to do effectively. Therefore, one of the tasks of intervention planning is to determine in what order practices should be implemented.

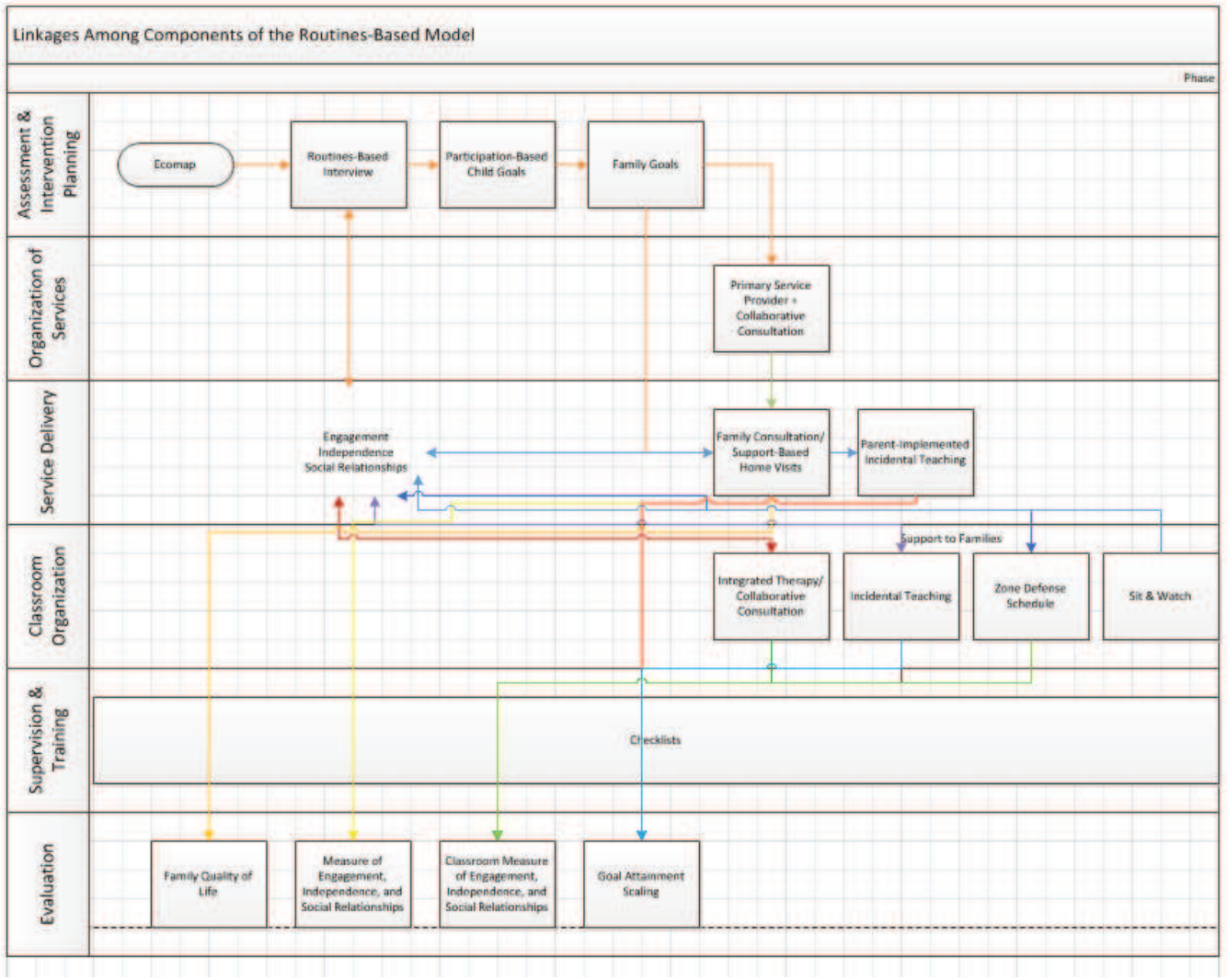

Figure 2. Guide for the Order of Implementation

Figure 2 shows the order in which the practices occur when serving children and families. This might not be the order entities want to implement the components, but it can serve as a guide. For example, we know from experience that, when entitites start with the RBI, many other things fall into place. Contrariwise, it would be hard to implement support-based home visits, for example, without a decent intervention plan. Therefore, implementation of the RBI should generally come before implementation of support-based home visits.

The 19th-century English philosopher Herbert Spencer said, "Every cause produces more than one effect." The intersecting lines in Figure 2 show that many components lead to more than one other component. The beauty of the RBM is that the components are logically linked but can be worked on separately. Working on one component intensively will produce more than one effect.

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