



Collaborative

Consultation = Equity;

Medical Model = Inequity



about me

I'm Professor Robin McWilliam.

Professor at The University of Alabama,
Founder of the Evidence-based International
Early Intervention Office (EIEIO) and the RAM
Group

Follow our work at www.eieio.ua.edu to learn
more.



01. Topic

02. Premise 1

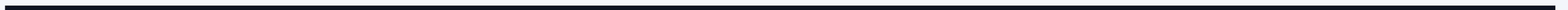
03. Premise 2

04. Premise 3

05. Conceptual framework

06. Argument

**table of
contents**



01.



Topic



**Collaborative
consultation = equity;
Medical model = inequity**

What are different models
of consultation?

Why is *consultation*
important?

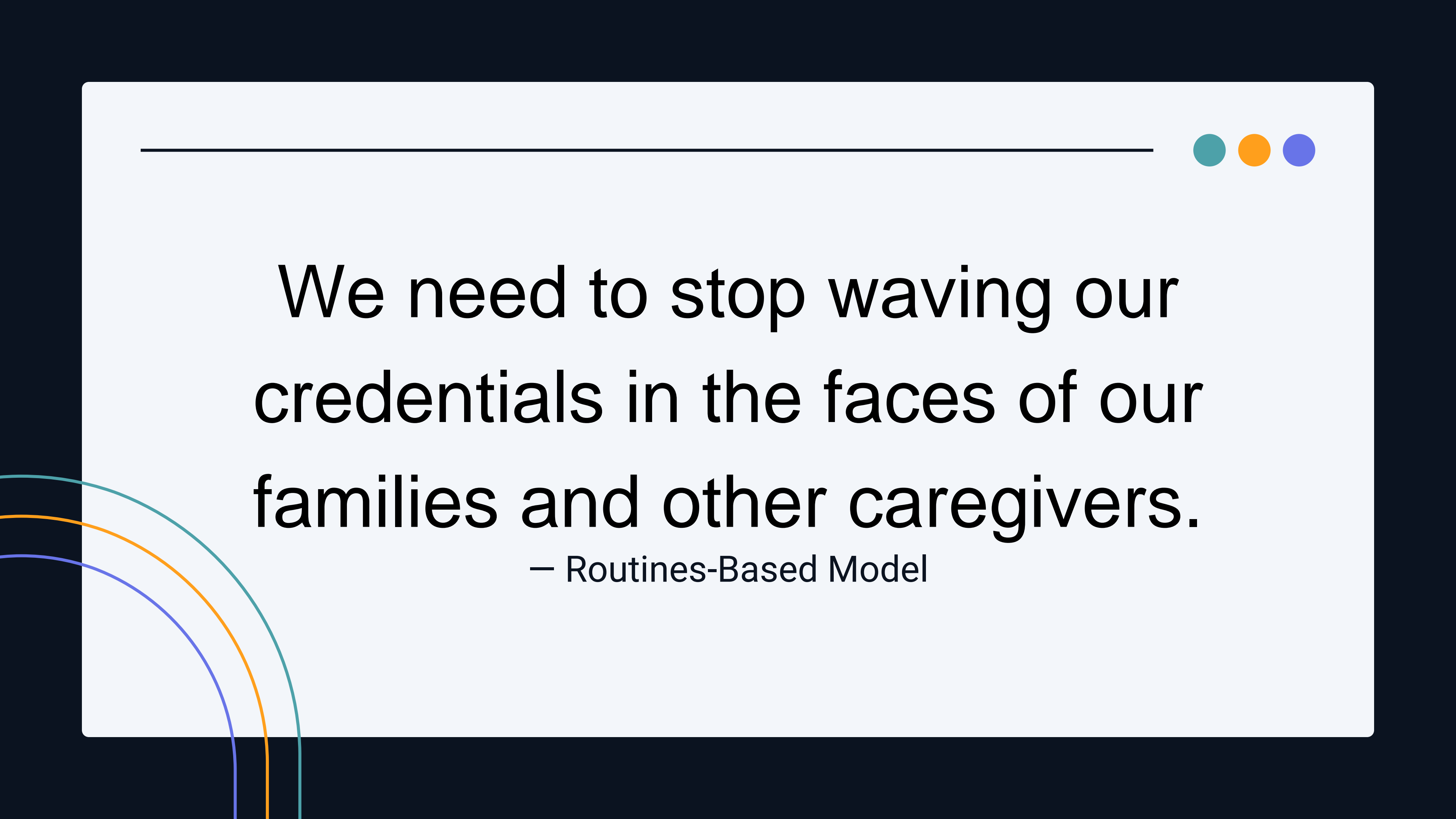
What are our emerging
ideas about equity?





“Not everything that is faced can be changed. But nothing can be changed until it is faced.”

— James Baldwin



We need to stop waving our
credentials in the faces of our
families and other caregivers.

— Routines-Based Model

02.



Premise 1



The purpose of the visit/session is to build the caregiver's capacity

How do we build capacity if we are quick to provide solutions?

Why is the caregiver's capacity so important?



Naturalenvironments.blogspot.com

EARLY INTERVENTION IN NATURAL ENVIRONMENTS

by Robin McWilliam, on topics related to the Routines-Based Model

Tuesday, March 22, 2022

The Social Construct of "Needing" Services

I'm so stupid that I studied for the Covid test.

If you test positive for Covid, you *need* to quarantine. If you test positive for cancer, you *need* to get radiation or chemotherapy —although you can opt out. If you break a leg, you *need* to be in a cast.

If your child has Down syndrome, she does not *need* occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP; as it's known in the United States). Needing a service in early intervention birth-5 is a social construction. A professional (especially a pediatrician), an organization, or an advocate might declare that a diagnosis presupposes a service. Oddly, pediatricians rarely say the child needs early intervention or early childhood special education. The prevalence of the **therapies** points to a medical-model mindset.

Topics

[assess](#)

[autism](#)

[behavio](#)

[classro](#)

[clinics](#)

[coachin](#)

[collabo](#)

[consult](#)

Monday, July 7, 2014

Self-Regulation in Working With Families

Home-based early interventionists need self-regulation too. In this post I discuss what relationship we have with families, who the hero of the visit is, and the Hoosiers Rule.

As we develop our relationship with families, do we present ourselves as the people with answers? To some extent, we do, to build the family's confidence in us and to show them they're not wasting their time hosting us. But if we always have the answers, what are we doing to families? We might be enhancing their dependence on us rather than their self-confidence as parents, problem solvers, and "case managers" for their child. As Anne Isabella Thackeray Ritchie wrote in her 1885 novel, *Mrs. Dymond*, "If you give a man a fish he is hungry again in an hour. If you teach him to catch a fish you do him a good turn."

We need to be careful not to try to be the hero of the visit, which can happen if we have all the answers—the strategies, the ideas, the suggestions, the information.... Getting into the car at the end of the visit, when we have given the family the gift of our creativity, wisdom, and knowledge, we feel self-satisfied. We feel useful. We are immediately gratified. This feeling is addictive. Many home visitors are absolutely convinced their role is to give families everything they can, right away. They are convinced because families love them and they themselves have that feeling of self-satisfaction at the end of home visits.

It is much harder to take the long view by taking the slower road. When a father asks me, "What should I do? It takes us one to two hours to get her to sleep," I can immediately start talking about what the medical people ridiculously call "sleep hygiene" (bedtime environment and ritual) and I can tell the father how to condition the child to decreasing attention time (fading). In the course of doing so, I would undoubtedly mention things they have tried, things they wouldn't like to try, things they wouldn't believe would work, and also some great ideas. It would be quite easy for me to feel like the hero of the visit.

03.



Premise 2





Stick the landing and dig in

When do we make a suggestion/recommendation?

What are the 3 possible actions?

What are the plausibility and feasibility questions?



04.



Premise 3



Critical discourse analysis

Saying

Informing.

Doing

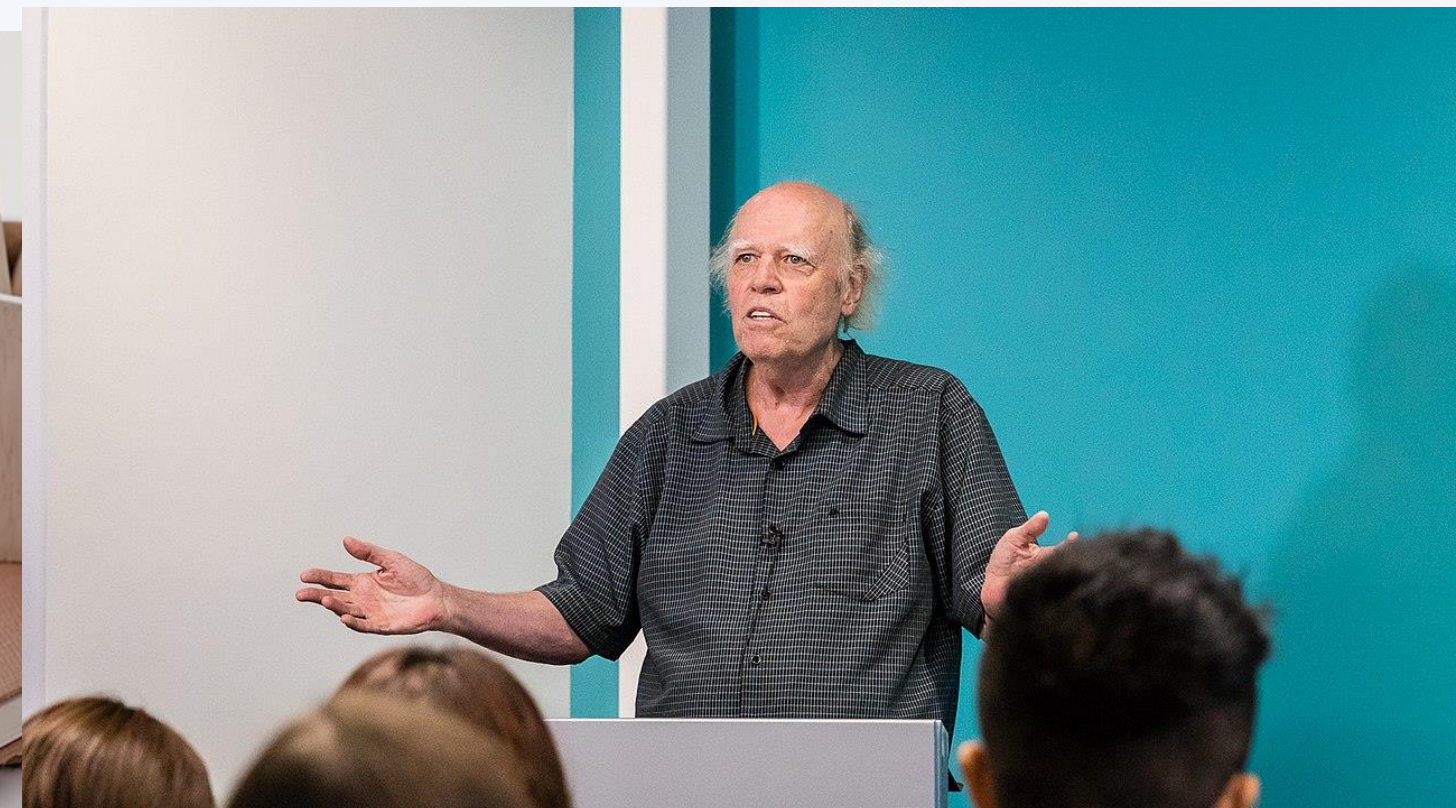
Action

Being

Identity (in the discourse).

James Paul Gee

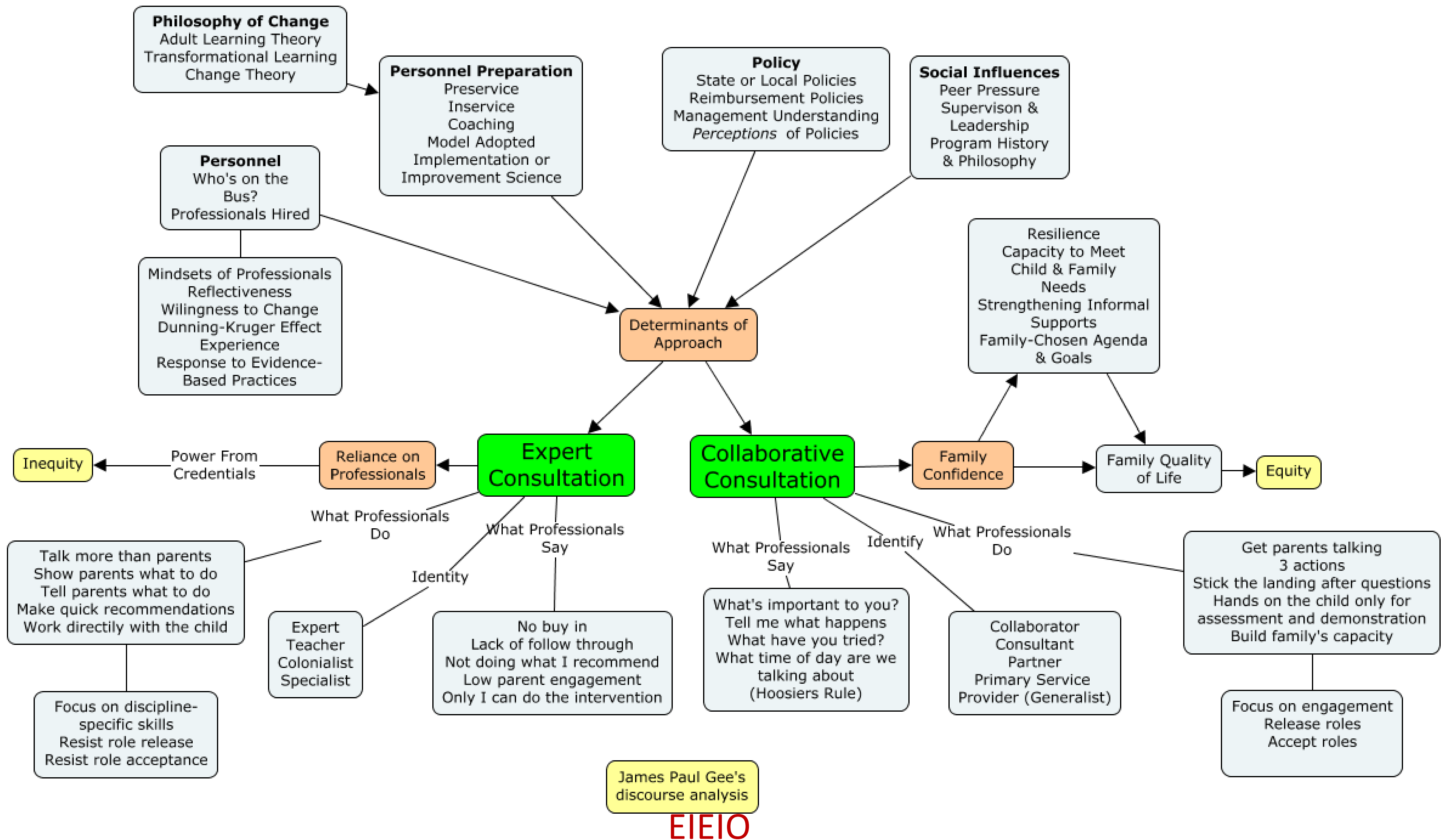
Professor of Literacy Studies,
Arizona State University (retired)



05.

The slide features a dark navy blue background. In the top left corner, the number '05.' is written in a large, white, serif font. A thin white horizontal line extends from the right side of the '05.' to the right edge of the slide. In the top right corner, there are three small orange dots arranged horizontally. Several thick, curved orange lines sweep across the slide, starting from the top and bottom edges and curving towards the right side.

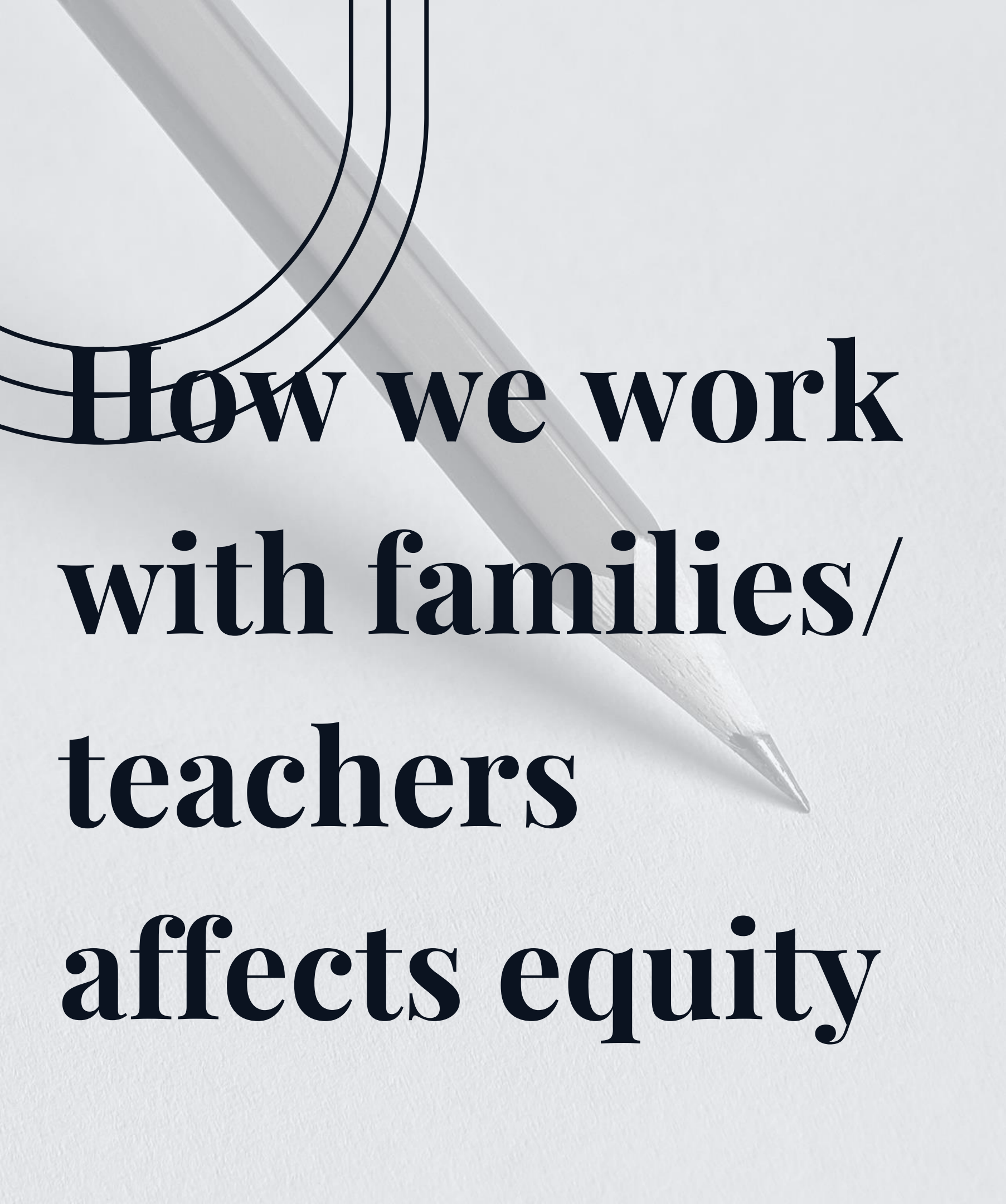
Conceptual Framework



06.



Argument



How we work with families/ teachers affects equity

Follow Hoosiers Rule

4 questions before suggestion.

Context of routines

Everyday relevance.

Check in with caregiver

Plausibility & feasibility.

EIEIO



Executive Team

Thanks for your collaboration!



Cami Stevenson

EIEIO Assoc. Dir.



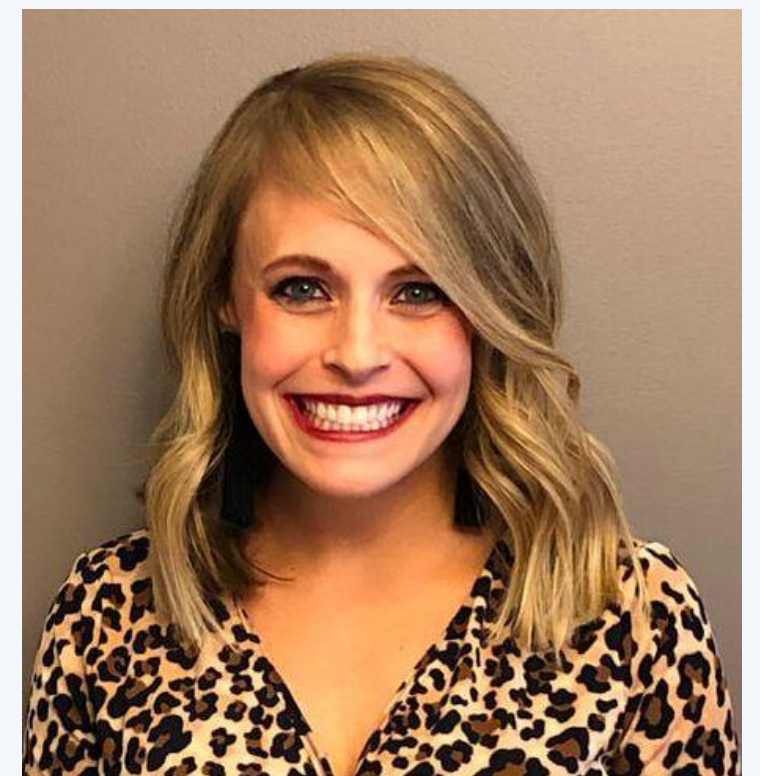
Pau García Grau

EIEIO European Dir



Catalina Morales Murillo

EIEIO European Co-Dir.



Kimberly Tomeny

El@UA Prog. Dir.



thank you!

Write to me at
ramcwilliam@ua.edu

