[Key Principles of Early Intervention and Effective Practices: A Crosswalk with Statements from Discipline-specific Literature]
This document is a comprehensive outcome of technical assistance provided to states in the Mountain Plains Region. Many states have been evaluating their early intervention practices and undergoing system change to incorporate Effective Practices related to providing services within the natural environment and implementing a primary service provider approach. Currently over 50% of states are utilizing the primary service provider approach to early intervention. This document is an effort to capture effective early intervention practices and position statements from professional organizations into one document.

The starting point was the document AGREED UPON PRACTICES FOR PROVIDING EARLY INTERVENTION SERVICES IN NATURAL ENVIRONMENTS, listing the concepts underlying the brief statements. The document, developed by the Workgroup on Principles and Practices in Natural Environments, reflects practices validated through multiple research, model demonstration and outreach projects implemented by work group members. The practices reflect consensus opinion of the work group members who avoided endorsing any specific practice model or approach. The practices suggest a flow of activities that need to occur during the IFSP process from first contacts through transition, and are not intended to be used as a sequential “checklist”. The readers should be advised that there will be variations in implementation due to state and local procedures.


Citations:

The principles identified in this document were cross walked with statements from the multidisciplinary professional organizations that provide support to early intervention services including:
- American Association on Intellectual and Developmental Disabilities (AAIDD)
- American Academy of Pediatrics (AAP)
- Division of Early Childhood of the Council for Exceptional Children (DEC)
- National Association for the Education of Young Children (NAEYC)
- National Association of School Psychologists (NASP)
- American Speech-Language-Hearing Association (ASHA)
- American Occupational Therapy Association (AOTA)
- American Physical Therapy Association (APTA)

States may find this document useful for reviewing the agreed upon practices across all disciplines. In some instances a professional organization may use different terms to refer to practices. This document reflects statements by professional organizations, but is not attributing meaning to those statements. At the end of the document are web links to each of the papers utilized in creating this document and also a glossary to ensure a common understanding of terms.
1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts

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<tr>
<th>Effective Practices</th>
<th>Statements by Professional Organizations</th>
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| • Learning activities and opportunities must be functional, based on child and family interest and enjoyment | **AAIDD**  
• All young children who are at-risk for or who have been identified with intellectual and/or developmental disabilities should have access to high-quality, affordable developmental services in natural environments.  
• When early childhood services are provided in natural environments, both children and families will experience increased community inclusion during early childhood and across the life span. |
| • Learning is relationship-based | **AAP**  
• Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care. |
| • Learning should provide opportunities to practice and build upon previously mastered skills | **AOTA**  
• Activities of daily living (ADL), including play and social participation, are the foundation for learning opportunities  
  ○ ... learning takes place in the context of relationships.  
  ○ ... working as part of a transdisciplinary early intervention team in natural environments.  
• Activities of daily living (ADL), including play and social participation, are the foundation for learning opportunities that have meaning to both the client (child and family) and practitioner. |
| • Learning occurs through participation in a variety of enjoyable activities | **APTA**  
• Natural environments are home (family life) and community-life settings that are natural and typical for children without a disability and their families.  
• Settings where the child, family, and care providers participate in everyday routines and activities that are important to them and serve as important learning opportunities. |
| | **ASHA**  
• Services are developmentally supportive and promote children's participation in their natural environments.  
• Early speech and language skills are acquired and used primarily for communicating during social interactions.  
  ○ ... intervention occurring within the child's and family's functional and meaningful routines.  
  ○ ... services and supports—including speech-language and audiology treatment—are provided in the locations where the families typically spend their time.  
• Children learn through participating in their everyday activities and meaningful experiences with their family and caregivers. |
| | **DEC / NAEYC**  
• Providing access to a wide range of learning opportunities, activities, settings, and environments is a defining feature of high quality early childhood inclusion.  
• Opportunities for learning in the child’s natural settings must be identified including the learning opportunities that occur in those settings.  
• More active involvement of parents in their child’s program appears to be related to greater developmental progress.  
• Regular caregivers and regular routines provide the most appropriate opportunities for children’s learning and receiving most other interventions.  
• Young children learn through ongoing interactions with their natural environment rather than in isolated lessons or sessions. |
| | **NASP**  
• Early environments matter and nurturing relationships are essential. |
2. All families, with the necessary supports and resources, can enhance their children’s learning and development

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| • All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources) | AAIDD
  • Parental involvement in any program is crucial for success, and early intervention is most effective when the families of children are fully involved. |
| • The consistent adults in a child’s life have the greatest influence on learning and development—not EI providers | AAP
  • Strong connections within a loving, supportive family, along with opportunities to interact with other children and grow in independence in an environment with appropriate structure, are important assets in a child’s life. |
| • All families have strengths and capabilities that can be used to help their child | AOTA
  • The outcome we seek under Part C is to support parents’ capacity to "captain their own ship" and not become dependent on professionals for all decision making. |
| • All families are resourceful, but all families do not have equal access to resources | APTA
  • ... depart from therapist-directed interactions to a side-by-side collaboration with families, creating the agenda together. |
| • Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities | ASHA
  • Children learn through participating in their everyday activities and meaningful experiences with their family and caregivers. When caregivers maximize learning opportunities in the child’s daily routines and activities, the child has many opportunities for intervention every day, throughout the day, and in a meaningful and responsive manner. |
| | DEC / NAEYC
  • Family-based practices provide or mediate the provision of resources and supports necessary for families to have the time, energy, knowledge and skills to provide their children learning opportunities and experiences that promote child competence and development. |
| | NASP
  • Parental involvement in any program is crucial for success, and early intervention is most effective when the families of children are fully involved.
3. **The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child’s life**

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| • EI providers engage with the adults to enhance confidence and competence in their inherent role as the people who teach and foster the child’s development | **AAIDD**  
- Families are the constant in children’s lives, and the primary source of lifelong support and early learning.  
- Families should be supported in making informed decisions and in partnering effectively with professionals to achieve positive outcomes.  

**AAP**  
- Families and providers work together as partners at all levels of decision making.  
- The concerns of both parents and child health professionals should be included in determining whether surveillance suggests that the child may be at risk of developmental problems.  
- A medical home provides patient- and family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity, and recognizing that they are the constant in a child’s life.  
- Providing sufficient information, encouraging partnership, being sensitive to values and customs, spending enough time, and listening to the family’s concerns are core elements of a medical home.  

**AOTA**  
- The expertise of the occupational therapist, and more importantly, that of the parent, emerge through the family-professional relationship.  
- Going into a home with an expectation of discovery, as opposed to the execution of a curriculum, means practitioners have begun to be with rather than do for the child and family.  
- OT practitioners can bring their “therapeutic use of self” to all team and family interactions, coaching and guiding rather than directing and doing.  

**APTA**  
- The choice of team approach should be based on the needs of the child and family:  
  - A shared framework of trust.  
  - Clearly defined roles and responsibilities.  
  - Respectful and empathetic open communication.  
- Provide families with emotional, informational, and material resources to support the achievement of Individualized Family Service Plan (IFSP) outcomes.  
- According to Chiarello and Kolobe, “team collaboration is the process of forming partnerships among family members, service providers, and the community with the common goal of enhancing the child’s development and supporting the family.”  

**ASHA**  
- Families provide a lifelong context for a child’s development and growth.  
- The family, rather than the individual child, is the primary recipient of services to the extent desired by the family.  
- Young children learn through familiar, natural activities, it is important for the SLP to provide information that promotes the parents’ and/or other caregivers’ abilities to implement communication-enhancing strategies during those everyday routines, creating increased learning opportunities and participation for the child.  
- The SLP shares information and resources, and coaches the parents about including communication activities throughout the child’s day, with content individualized to meet the specific needs of the child.  
- SLPs should look for ways to join in the caregiver-child interactions, rather than expecting the caregiver to observe or join the SLP-child activities.
DEC / NAEYC
- Families are the constant in a child’s life, thus practices should honor and facilitate the family’s caregiving and decision-making roles.
- Families or parents are considered central and the most important decision maker in a child’s life.
- Family members, practitioners, specialists, and administrators should have access to ongoing professional development and support to acquire the knowledge, skills, and dispositions required to implement effective inclusive practices.
- Recognizing the central role of the family, providers, agencies and family members must work together as a team rather than as individuals.

NASP
- We must work with school administrators, teachers, and families to develop comprehensive intervention programs that are developmentally appropriate, family centered, and sensitive to cultural and linguistic differences.
4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child’s and family members’ preferences, learning styles and cultural beliefs

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<td>Families are active participants in all aspects of services</td>
<td>AAIDD - Children and families must have access to a system of evidence-based services which is community-based and coordinated and responsive to individual and cultural differences.</td>
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<td>Families are the ultimate decision makers in the amount, type of assistance and the support they receive</td>
<td>AAIDD - Services should build on the strengths of the child and family, address their needs, and be responsive to their culture and personal priorities.</td>
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<td>Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly</td>
<td>AAP - Patients and families participate in quality improvement activities at the practice level.</td>
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<td>The adults in a child’s life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals</td>
<td>AAP - Families are respected and listened to and receive appropriate information necessary to share in decision making on behalf of their child.</td>
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<td>Each family’s culture, spiritual beliefs and activities, values and traditions will be different from the service provider’s (even if from a seemingly similar culture); service providers should seek to understand, not judge</td>
<td>AOTA - We must understand each stage of the child’s emotional development in order to create effective intervention activities and to engage the parent and child in nurturing, contingent, empathic interactions.</td>
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<td>Family “ways” are more important than provider comfort and beliefs (short of abuse/neglect)</td>
<td>AOTA - AOTA endorses the concepts of collaboration, teamwork, and family-centered care.</td>
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<td>APTA - Invite and encourage families and care providers to identify their priorities and outcomes as an initial step in the planning process.</td>
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<td>APTA - Strengthen and develop lifelong natural supports for children and families.</td>
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<td>APTA - Recognize family members and care providers as the primary influence for nurturing growth, development, and learning.</td>
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<td>ASHA - Services Are Family-Centered and Culturally Responsive: An aim of all early intervention services and supports is responsiveness to family concerns for each child’s strengths, needs, and learning styles.</td>
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<td>ASHA - An important component of individualizing services includes the ability to align services with each family's culture and unique situation, preferences, resources, and priorities.</td>
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<td>DEC / NAEYC - Respect for all children and families is a fundamental value supported by DEC.</td>
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<td>DEC / NAEYC - Teachers and others who work with and on behalf of children and families must respect, value, and support the culture, values, and languages of each home and promote the active participation of all families.</td>
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<td>NASP - Practitioners’ use ongoing data to individualize and adapt practices to meet each child's changing needs.</td>
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<td>NASP - Cultural differences between service providers and families must be recognized.</td>
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<td>NASP - Practitioners must be aware that families’ communication styles, belief systems, and perceptions of disability, may vary greatly from their own.</td>
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<td>NASP - Provide advocacy and leadership in building comprehensive, collaborative systems of care that value parents as equal partners, respect individual differences and incorporate multicultural perspectives while insuring access to high-quality early educational environments for all young children.</td>
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5. **IFSP outcomes must be functional and based on children’s and families’ needs and priorities**

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| • Functional outcomes improve participation in meaningful activities | **AAIDD**  
  • Early childhood services should also provide family support that responds to families’ strengths and needs and improves family quality of life. |
| • Functional outcomes build on natural motivations to learn and do; fit what’s important to families; strengthen naturally occurring routines; enhance natural learning opportunities | **AAP**  
  • Parents and child health professionals have valuable observation skills, and they share the goal of ensuring optimal health and developmental outcome for the child. In the optimal situation, the child health professional elicits parental observations, experiences, and concerns and recognizes that parental concerns mandate serious attention.  
  • Emphasize care that puts the patient first, emphasizes open communication, and supports the patient and his or her caregivers.  
  • Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met  
  • Management plans should be based on a comprehensive need assessment conducted with the family.  
  • A medical home means that your pediatric primary care provider knows your child's health history, listens to your concerns and needs (as well as your child’s), treats your child with compassion, has an understanding of his/her strengths, develops a care plan with you and your child when needed, and respects and honors your culture and traditions. |
| • The family understands that strategies are worth working on because they lead to practical improvements in child & family life | **AOTA**  
  • When developing an IFSP with a family, outcomes, for example, reflect their hopes for the child’s participation in home and community life (“We want our daughter to notice us”) rather than discipline-specific objectives (“Jenny will look at her parents on prompting three of five trials”).  
  • Methods describe coaching the parent within regular family activities rather than exclusively therapist-child interactions.  
  • Involving the parents and other family members in the evaluation process also establishes the importance of including them from the outset of intervention.  
  • Listening to and learning from what the family has to say goes a long way toward designing effective early intervention for a child with disabilities. |
| • Functional outcomes keep the team focused on what’s meaningful to the family in their day to day activities | **APTA**  
  • Emphasize children’s, families’, and care providers’ abilities during everyday activities, rather than teaching a new skill out of context.  
  • Provide physical therapy within the context of family and child routines and activities. |
|  | **ASHA**  
  • Consultative and collaborative models are closely aligned with inclusive practices; involve services delivered in natural environments, and focus on functional communication during the child and family’s natural daily activities and routines.  
  • Functional and meaningful child communication goals reflecting the family’s priorities are critical.  
  • A thorough exploration of the caregiver’s objectives for the child will enhance the development of goals for consultation and lead to clear, relevant, and jointly established expectations.  
  • Agreeing upon the learning priorities promotes collaboration. |
|  | **DEC / NAEYC**  
  • Team members focus on the individual child’s functioning (e.g. engagement, independence, social relationships) in the contexts in which he or she lives not the service. |
- Functionality is stressed to ensure that children receive intervention aimed at valued outcomes or outcomes that matter in their daily lives.

**NASP**
- Developmentally appropriate practices take into account what is known about child development and learning, what is known about the unique needs, strengths and interests of each child, and what is known about the cultural and social environments in which each child lives.
- Parents should be encouraged to target goals for their child, learn about their legal rights and responsibilities and exchange information with providers.
6. The family’s priorities, needs, and interests are addressed most appropriately by a primary provider* who represents and receives team and community support

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<td>▪ The team can include friends, relatives, and community support people, as well as specialized service providers</td>
<td>▪ The medical home works with a coordinated team, provides ongoing primary care, and facilitates access to and coordinates with, a broad range of specialty, ancillary and related community services.</td>
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<td>▪ Uses good teaming practices</td>
<td>▪ Establishing an effective and efficient partnership with early childhood professionals is an important ingredient of successful care coordination for children within the medical home.</td>
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<td>▪ One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family’s life</td>
<td>▪ In early intervention, a variety of team models may be utilized, including a multidisciplinary, interdisciplinary, or transdisciplinary (including primary provider) approach.</td>
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<td>▪ The primary provider brings in other services and supports as needed, assuring outcomes, activities, and advice are compatible with family life and won’t overwhelm or confuse family members</td>
<td>▪ The very nature of that which occupational therapy addresses, engagement in daily occupations, can be fostered in a number of ways that can be identified by the occupational therapy practitioner and implemented on a daily basis by the family or others.</td>
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(Footnote: *Primary provider and transdisciplinary method may be used interchangeably in some instances and in others have different meanings. Refer to the Glossary at the end of the document for definitions)
implemented as a primary provider model.

- The use of transdisciplinary models with a primary service provider may be appropriate for SLPs.
- Teams benefit from joint professional development and also can enhance each other's knowledge and skills through role extension and role release for specific children and families.
- SLPs may serve as either primary providers or consultants in transdisciplinary models, and should be considered for the primary provider role when the child’s main needs are communication or feeding and swallowing.
- In some instances, one professional on the team is designated as the primary service provider (PSP); this model helps avoid fragmentation of services and frequent home visits from multiple professionals.
- When using the PSP model, the team must communicate regularly to support one another—as well as the child and family—to ensure maximum progress.
- The designation of the PSP should be a team decision and individualized for each child and family.

**DEC / NAEYC**

- Transdisciplinary model of service delivery is recommended to avoid fracturing (or segregating) services along disciplinary lines.
- A critical value embedded in transdisciplinary practices is the exchange of competencies between team members.
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations

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<td>• Practices must be based on and consistent with explicit principles</td>
<td>AAIDD - Services should be delivered through research-based practices.</td>
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<tr>
<td>• Providers should be able to provide a rationale for practice decisions</td>
<td>AAP - Decisions regarding appropriate therapies and their scope and intensity should be determined in consultation with the child’s family, therapists, and educators (including early intervention or school-based programs) and should be based on knowledge of the scientific evidence for their use.</td>
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<td>• Research is on-going and informs evolving practices</td>
<td>AAP - Evidence-based medicine and clinical decision-support tools guide decision making.</td>
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<tr>
<td>• Practice decisions must be data-based and ongoing evaluation is essential</td>
<td>AOTA - AOTA is currently sponsoring an evidence-based literature review on occupational therapy and early intervention.</td>
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<td>• Practices must fit with relevant laws and regulations</td>
<td>AOTA - Physical therapists apply the latest research related to restoring function, reducing pain, and preventing injury.</td>
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<td>• As research and practice evolve, laws and regulations must be amended accordingly</td>
<td>APTA - Hooked on Evidence is APTA's &quot;grassroots&quot; effort to develop a database containing current research evidence and clinical scenarios on the effectiveness of physical therapy interventions.</td>
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AAIDD

• Services should be delivered through research-based practices.

AAP

• Decisions regarding appropriate therapies and their scope and intensity should be determined in consultation with the child’s family, therapists, and educators (including early intervention or school-based programs) and should be based on knowledge of the scientific evidence for their use.

• Evidence-based medicine and clinical decision-support tools guide decision making.

AOTA

• AOTA is currently sponsoring an evidence-based literature review on occupational therapy and early intervention.

APTA

• Physical therapists apply the latest research related to restoring function, reducing pain, and preventing injury.

• Hooked on Evidence is APTA’s "grassroots" effort to develop a database containing current research evidence and clinical scenarios on the effectiveness of physical therapy interventions.

ASHA

• The ASHA Position Paper document includes conclusions and recommendations derived from available empirical evidence that were formed by consensus of the ASHA Ad Hoc Committee on the Role of the Speech-Language Pathologist in Early Intervention through five face-to-face meetings and nine phone conferences between November 2004 and December 2007.

• SLPs recognize that in areas for which empirical evidence is lacking, extrapolations from evidence with other populations and applications of principles stemming from theoretical models, societal norms, and government mandates and regulations also are relevant for decision making.

• Services are based on the highest quality internal and external evidence that is available: Early intervention practices are based on an integration of the highest quality and most recent research, informed professional judgment and expertise, and family preferences and values.

• Research about service delivery models in early intervention is in an emerging phase, and as a result, some practices may be based more on policy and professional and family preferences than on theories or research.

DEC / NAEYC

• DEC Recommended Practices have two primary goals to:

1. Produce an empirically supported set of recommendations for practice with young children with disabilities birth through age 5, their families, and those who work with them.

2. To increase the likelihood of the use and adoption of the Recommended Practices by identifying “indirect supports” necessary for improving direct service practice.

• Practices are supported by research evidence; experience and values of stakeholders and field validation.

• The field now has a good deal of research for guiding Practitioners’ decisions related to organizing and influencing children’s experiences.
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<td>• NASP encourages the use of empirically based, culturally sensitive, developmentally appropriate practices that are implemented in the child’s natural environment whenever possible.</td>
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<td>• Ideally, the school psychologist must work in unison with other early childhood intervention professionals to ensure that programs are based on methods with solid empirical support.</td>
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<td>• Utilize research from areas of child development, developmental psychopathology, risk and resilience, and disability prevention to promote adoption of empirically demonstrated instructional practices in areas such as emergent literacy, socialization and problem-solving skills and self-management.</td>
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</table>
"Natural environments" is the term used in the Individuals with Disabilities Education Improvement Act, Part C (IDEA, 2004) to refer to settings that are typical for infants and toddlers without disabilities or delays. It is used as a contrast to more traditional treatment settings—such as clinical or medical-based programs—and includes families' homes, early care and education programs, and other community settings where families spend the most time with their children.

**Transdisciplinary** -- the emphasis on crossing disciplinary boundaries, and sharing expertise, roles, and responsibilities while recognizing the child as a whole within the context of the family (Mayhew, Scott, McWilliam, 1999; Gargiulo & Kilgo, 2000; Woodruff & McGonigel, 1988). Team members maintain a collaborative focus on functional and meaningful proficiencies within the context of the family and their day-to-day life. A primary service provider who works in close collaboration with the other team members integrates and synthesizes shared information to deliver efficient and comprehensive services. Respecting the family as a fully contributing, decision-making team member is another significant tenet of the transdisciplinary model, which reflects the highest degree of family-centeredness (Woodruff & McGonigel, 1988).

**Primary Service Provider** -- one professional provides weekly support to the family, backed up by a team of other professionals who provide services to the child and family through joint home visits with the primary service provider. The intensity of joint home visits depends on child, family, and primary-service-provider needs (McWilliam, 2010).

**Primary Coach Approach to teaming** assigns one member of a multidisciplinary team as the primary coach, where he/she receives coaching from other team members, and uses coaching with parents and other primary caregivers to support and strengthen their confidence and competence in promoting child learning and development. A primary coach approach to teaming differs from other approaches to teaming in which one practitioner serves as the primary liaison between the family and other team members (Woodruff & McGonigel, 1988; York, Rainforth, & Giangreco, 1990) by its explicit focus on the type and content of interactions between team members and their roles for promoting parent skills, knowledge, and attributions. (This may also be referred to as primary provider.)

**Functional Outcomes** -- refer to things that are meaningful to the child in the context of everyday living and an integrated series of behaviors or skills that allow the child to achieve the important everyday goals.

**Family-Centered Principles** -- are a set of interconnected beliefs and attitudes that shape directions of program philosophy and behavior of personnel as they organize and deliver services to children and families. Core to family-centered services is sensitivity and respect for the culture and values of individual family members and each family's ecology, as members define the people, activities and beliefs important to them. The purpose of early intervention is to achieve family outcomes as well as child outcomes. Preschool special education services must include family involvement as well as accomplish child outcomes. Formal definitions of Family-Centered Services exist in the fields of social services, child welfare, developmental disabilities, early childhood and children's health care. While the definitions are different, there are common words and descriptions among them all. These common descriptors include: strengths based, consumer...
driven, family systems, family support, empowerment, proactive service delivery, promotion, competency focused, partnerships, collaborative relationships, family drive (Pletcher & McBride, 2003).

**Medical Home** -- AAP describes the Pediatric Medical Homes: Laying the Foundation of a Promising Model of Care medical home as, “a model of delivering primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.” Once identified, children with special health care needs (CSHCN) require a medical home: a source of ongoing routine health care in their community where providers and families work as partners to meet the needs of children and families. The medical home assists in the early identification of special health care needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services.

**Role Release** -- team members put newly acquired techniques into practice under the supervision of team members from the discipline that has accountability for those practices.

**Teaming** -- interventionists practice role release and role expansion. Regularly scheduled team meetings and consultations provide opportunities for exchange of information and training for the whole team. All members support the primary service provider.

**SOURCES**

The ARC of the United States (ARC) and the American Association on Intellectual and Developmental Disabilities (AAIDD)
- The ARC and AAIDD Position Statement, Early Childhood Services, August 4, 2008
  [http://www.aaidd.org/media/PDFs/LifeinCommunity/Early%20Childhood%20Services.pdf](http://www.aaidd.org/media/PDFs/LifeinCommunity/Early%20Childhood%20Services.pdf)

American Academy of Pediatrics (AAP), et al.
- Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening, Pediatrics Vol. 118 No. 1 July 1, 2006, pp. 405 -420
  [http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405)
- Access to the Medical Home: Results of the National Survey of Children with Special Health Care Needs, Bonnie Strickland, PhD, Merle McPherson, MD, Gloria Weissman, MA, Peter van Dyck, MD, Zhihuan J. Huang, MB, PhD, MPH, Paul Newacheck, DrPH. Pediatrics Vol. 113 No. Supplement 4, May 1, 2004, pp. 1485 -1492
  [http://pediatrics.aappublications.org/content/113/Supplement_4/1485.full](http://pediatrics.aappublications.org/content/113/Supplement_4/1485.full)
Division for Early Childhood (DEC) [www.dec-sped.org](http://www.dec-sped.org) and National Association for the Education of Young Children (NAEYC) [http://www.naeyc.org/](http://www.naeyc.org/)

- Early Childhood Inclusion A Joint Position Statement of the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC)

National Association of School Psychologists (NASP)

- NASP Position Statement on Early Intervention Services, Revision adopted by NASP Delegate Assembly, April 12, 2003
  [http://caspsurveys.org/NEW/pdfs/nasp01.pdf](http://caspsurveys.org/NEW/pdfs/nasp01.pdf)

American Speech-Language-Hearing Association (ASHA)

- March 25, 2008 Feature Providing Early Intervention Services in Natural Environments by Juliann Woods


American Occupational Therapy Association (AOTA)

- Side by Side: Transdisciplinary Early Intervention in Natural Environments, Kristine Ovland Pilkington, 04-03-06

- AOTA Practice Advisory on Occupational Therapy in Early Intervention, July 2010

American Physical Therapy Association (APTA)

- Natural Environments in Early Intervention, Practice Committee of the Section on Pediatrics, APTA, 2008

- Integrating Therapy into the Classroom, National Individualizing Preschool Inclusion Project, R A McWilliam, Stacy Scott, August 2003

RRCP Early Childhood Service Delivery Priority Team provided review and technical assistance to this document. Members of the team included Betsy Ayankoya, Sharon Ringwalt, Ann Bailey, Sharon Walsh, Sue Goode, Joicey Hurth, Anne Lucas, Karen Mikkelson, and Lynda Pletcher.

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APPENDICES – Key Principles of Early Intervention and Effective Practices: A Crosswalk with Statements from Discipline-specific Literature

- ARC of the United States & American Association on Intellectual and Developmental Disabilities position statements
- American Academy of Pediatrics, et al. position statements
- American Occupational Therapy position statements
- American Physical Therapy Association position statement
- American Speech-Language-Hearing Association position statement
- Division for Early Childhood & National Association for the Education of Young Children position statements
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[Key Principles of Early Intervention and Effective Practices: A Crosswalk with the ARC of the United States and the American Association on Intellectual and Developmental Disabilities Position Statement]
This document is a comprehensive outcome of technical assistance provided to state Part C programs in the Mountain Plains Region. Many states have been evaluating their early intervention practices and undergoing system change to incorporate Effective Practices related to providing services within the natural environment and implementing a primary service provider approach. Currently over 50% of states are utilizing the primary service provider approach to early intervention. This document is an effort to capture effective early intervention practices and position statements from the ARC of the United States (ARC) and the American Association on Intellectual and Developmental Disabilities (AAIDD) into one document.

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Citations:

- Workgroup on Principles and Practices in Natural Environments (Final Draft 11-07) Agreed upon practices for providing early intervention services in natural environments. OSEP TA Community of Practice- Part C Settings.
  http://www.nectac.org/topics/natenv/natenv.asp
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<th>Effective Practices</th>
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<tr>
<td><strong>1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts</strong>&lt;br&gt;• Learning activities and opportunities must be functional, based on child and family interest and enjoyment&lt;br&gt;• Learning is relationship-based&lt;br&gt;• Learning should provide opportunities to practice and build upon previously mastered skills&lt;br&gt;• Learning occurs through participation in a variety of enjoyable activities</td>
<td>• All young children who are at-risk for or who have been identified with intellectual and/or developmental disabilities should have access to high-quality, affordable developmental services in natural environments.&lt;br&gt;• When early childhood services are provided in natural environments, both children and families will experience increased community inclusion during early childhood and across the life span.</td>
</tr>
<tr>
<td><strong>2. All families, with the necessary supports and resources, can enhance their children’s learning and development</strong>&lt;br&gt;• All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources)&lt;br&gt;• The consistent adults in a child’s life have the greatest influence on learning and development—not EI providers&lt;br&gt;• All families have strengths and capabilities that can be used to help their child&lt;br&gt;• All families are resourceful, but all families do not have equal access to resources&lt;br&gt;• Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities</td>
<td>• Parental involvement in any program is crucial for success, and early intervention is most effective when the families of children are fully involved.</td>
</tr>
<tr>
<td><strong>3. The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child’s life</strong>&lt;br&gt;• EI providers engage with the adults to enhance confidence and competence in their inherent role as the people who teach and foster the child’s development&lt;br&gt;• Families are equal partners in the relationship with service providers&lt;br&gt;• Mutual trust, respect, honesty and open communication characterize the family-provider relationship</td>
<td>• Families are the constant in children’s lives, and the primary source of lifelong support and early learning.&lt;br&gt;• Families should be supported in making informed decisions and in partnering effectively with professionals to achieve positive outcomes.</td>
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<td><strong>4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child’s and family members’ preferences, learning styles and cultural beliefs</strong>&lt;br&gt;• Families are active participants in all aspects of services&lt;br&gt;• Families are the ultimate decision makers in the amount, type of assistance and the support they receive&lt;br&gt;• Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly&lt;br&gt;• The adults in a child’s life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals&lt;br&gt;• Each family’s culture, spiritual beliefs and activities, values and traditions will be different from the service provider’s (even if from a seemingly similar culture); service providers should seek to</td>
<td>• Children and families must have access to a system of evidence-based services which is community-based and coordinated and responsive to individual and cultural differences.&lt;br&gt;• Services should build on the strengths of the child and family, address their needs, be responsive to their culture and personal priorities.</td>
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<tr>
<td>understand, not judge</td>
<td>• Early childhood services should also provide family support that responds to families’ strengths and needs and improves family quality of life.</td>
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<td>• Family “ways” are more important than provider comfort and beliefs (short of abuse/neglect)</td>
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5. **IFSP outcomes must be functional and based on children’s and families’ needs and priorities**
   - Functional outcomes improve participation in meaningful activities
   - Functional outcomes build on natural motivations to learn and do; fit what’s important to families; strengthen naturally occurring routines; enhance natural learning opportunities
   - The family understands that strategies are worth working on because they lead to practical improvements in child & family life
   - Functional outcomes keep the team focused on what’s meaningful to the family in their day to day activities

6. **The family’s priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support**
   - The team can include friends, relatives, and community support people, as well as specialized service providers.
   - Good teaming practices are used
   - One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family’s life
   - The primary provider brings in other services and supports as needed, assuring outcomes, activities and advice are compatible with family life and won’t overwhelm or confuse family members

7. **Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations**
   - Practices must be based on and consistent with explicit principles
   - Providers should be able to provide a rationale for practice decisions
   - Research is on-going and informs evolving practices
   - Practice decisions must be data-based and ongoing evaluation is essential
   - Practices must fit with relevant laws and regulations
   - As research and practice evolve, laws and regulations must be amended accordingly

**SOURCE**

3 | Page  | November 1, 2012
The ARC of the United States (ARC) and American Association on Intellectual and Developmental Disabilities (AAIDD)

  
  [http://www.aaidd.org/media/PDFs/LifeinCommunity/Early%20Childhood%20Services.pdf](http://www.aaidd.org/media/PDFs/LifeinCommunity/Early%20Childhood%20Services.pdf)

**GLOSSARY**

"**Natural environments**" is the term used in the Individuals with Disabilities Education Improvement Act, Part C (IDEA, 2004) to refer to settings that are typical for infants and toddlers without disabilities or delays. It is used as a contrast to more traditional treatment settings—such as clinical or medical-based programs—and includes families' homes, early care and education programs, and other community settings where families spend the most time with their children.

**Transdisciplinary** -- the emphasis on crossing disciplinary boundaries, and sharing expertise, roles, and responsibilities while recognizing the child as a whole within the context of the family (Mayhew, Scott, McWilliam, 1999; Gargiulo & Kilgo, 2000; Woodruff & McGonigel, 1988). Team members maintain a collaborative focus on functional and meaningful proficiencies within the context of the family and their day-to-day life. A primary service provider who works in close collaboration with the other team members integrates and synthesizes shared information to deliver efficient and comprehensive services. Respecting the family as a fully contributing, decision-making team member is another significant tenet of the transdisciplinary model, which reflects the highest degree of family-centeredness (Woodruff & McGonigel, 1988).

**Primary Service Provider** -- one professional provides weekly support to the family, backed up by a team of other professionals who provide services to the child and family through joint home visits with the primary service provider. The intensity of joint home visits depends on child, family, and primary-service-provider needs (McWilliam, 2010).

**Primary Coach Approach to teaming** assigns one member of a multidisciplinary team as the primary coach, where he/she receives coaching from other team members, and uses coaching with parents and other primary caregivers to support and strengthen their confidence and competence in promoting child learning and development. A primary coach approach to teaming differs from other approaches to teaming in which one practitioner serves as the primary liaison between the family and other team members (Woodruff & McGonigel, 1988; York, Rainforth, & Giangreco, 1990) by its explicit focus on the type and content of interactions between team members and their roles for promoting parent skills, knowledge, and attributions. (This may also be referred to as primary provider.)

**Functional Outcomes** -- refer to things that are meaningful to the child in the context of everyday living and an integrated series of behaviors or skills that allow the child to achieve the important everyday goals.

**Family-Centered Principles** -- are a set of interconnected beliefs and attitudes that shape directions of program philosophy and behavior of personnel as they organize and deliver services to children and families. Core to family-centered services is sensitivity and respect for the culture and values of individual family
members and each family's ecology, as members define the people, activities and beliefs important to them. The purpose of early intervention is to achieve family outcomes as well as child outcomes. Preschool special education services must include family involvement as well as accomplish child outcomes. Formal definitions of Family-Centered Services exist in the fields of social services, child welfare, developmental disabilities, early childhood and children's health care. While the definitions are different, there are common words and descriptions among them all. These common descriptors include: strengths based, consumer driven, family systems, family support, empowerment, proactive service delivery, promotion, competency focused, partnerships, collaborative relationships, family driven (Pletcher & McBride, 2003).

**Medical Home** -- AAP describes the Pediatric Medical Homes: Laying the Foundation of a Promising Model of Care medical home as, “a model of delivering primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.” Once identified, children with special health care needs (CSHCN) require a medical home: a source of ongoing routine health care in their community where providers and families work as partners to meet the needs of children and families. The medical home assists in the early identification of special health care needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services.

**Role Release** -- team members put newly acquired techniques into practice under the supervision of team members from the discipline that has accountability for those practices.

**Teaming** -- interventionists practice role release and role expansion. Regularly scheduled team meetings and consultations provide opportunities for exchange of information and training for the whole team. All members support the primary service provider.

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With Support from the RRCP Early Childhood Service Delivery Priority Team

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- Learning activities and opportunities must be functional, based on child and family interest and enjoyment  
- Learning is relationship-based  
- Learning should provide opportunities to practice and build upon previously mastered skills  
- Learning occurs through participation in a variety of enjoyable activities | - Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care. |
| **2. All families, with the necessary supports and resources, can enhance their children’s learning and development**  
- All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources)  
- The consistent adults in a child’s life have the greatest influence on learning and development—not EI providers  
- All families have strengths and capabilities that can be used to help their child  
- All families are resourceful, but all families do not have equal access to resources  
- Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities | - Strong connections within a loving, supportive family, along with opportunities to interact with other children and grow in independence in an environment with appropriate structure, are important assets in a child’s life. |
| **3. The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child’s life**  
- EI providers engage with the adults to enhance confidence and competence in their inherent role as the people who teach and foster the child’s development  
- Families are equal partners in the relationship with service providers  
- Mutual trust, respect, honesty and open communication characterize the family-provider relationship | - Families and providers work together as partners at all levels of decision making.  
- The concerns of both parents and child health professionals should be included in determining whether surveillance suggests that the child may be at risk of developmental problems.  
- A medical home provides patient- and family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity, and recognizing that they are the constant in a child’s life.  
- Providing sufficient information, encouraging partnership, being sensitive to values and customs, spending enough time, and listening to the family’s concerns are core elements of a medical home. |
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<td>5. <strong>IFSP outcomes must be functional and based on children’s and families’ needs and</strong></td>
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### AAP Position Statements

- The medical home works with a coordinated team, provides ongoing primary care, and facilitates access to and coordinates with, a broad range of specialty, ancillary and related community services.
- Establishing an effective and efficient partnership with early childhood professionals is an important ingredient of successful care coordination for children within the medical home.
- Decisions regarding appropriate therapies and their scope and intensity should be determined in consultation with the child’s family, therapists, and educators (including early intervention or school-based programs) and should be based on knowledge of the scientific evidence for their use.
- Evidence-based medicine and clinical decision-support tools guide decision making.

### SOURCE

American Academy of Pediatrics, et al.
- Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening, Pediatrics Vol. 118 No. 1 July 1, 2006, pp. 405 -420
  [http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405)
- Access to the Medical Home: Results of the National Survey of Children with Special Health Care Needs, Bonnie Strickland, PhD, Merle McPherson, MD, Gloria Weissman, MA, Peter van Dyck, MD, Zhihuan J. Huang, MB, PhD, MPH, Paul Newacheck, DrPH. Pediatrics Vol. 113 No. Supplement 4, May 1, 2004, pp. 1485 -1492
  [http://pediatrics.aappublications.org/content/113/Supplement_4/1485.full](http://pediatrics.aappublications.org/content/113/Supplement_4/1485.full)
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| **1. Infants and toddlers learn best through everyday experiences and interactions with**| • Activities of daily living (ADL), including play and social participation, are the foundation for learning opportunities:  
  • ... learning takes place in the context of relationships.  
  • ... working as part of a transdisciplinary early intervention team in natural environments.                                                                 |
| **familiar people in familiar contexts.**                                              |                                                                                                                                                                                                                            |
| • Learning activities and opportunities must be functional, based on child and family interest and enjoyment  
  • Learning is relationship-based  
  • Learning should provide opportunities to practice and build upon previously mastered skills  
  • Learning occurs through participation in a variety of enjoyable activities |                                                                                                                                                                                                                            |
| **2. All families, with the necessary supports and resources, can enhance their children’s**| • The outcome we seek under Part C is to support parents' capacity to "captain their own ship" and not become dependent on professionals for all decision making.  
  • ... depart from therapist-directed interactions to a side-by-side collaboration with families, creating the agenda together. |}
| **learning and development**                                                          |                                                                                                                                                                                                                            |
| • All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources)  
  • The consistent adults in a child’s life have the greatest influence on learning and development—not EI providers  
  • All families have strengths and capabilities that can be used to help their child  
  • All families are resourceful, but all families do not have equal access to resources  
  • Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities |                                                                                                                                                                                                                            |
| **3. The primary role of the service provider in early intervention is to work with and support**| • The expertise of the occupational therapist, and more importantly, that of the parent, emerge through the family-professional relationship.  
  • Going into a home with an expectation of discovery, as opposed to the execution of a curriculum, means practitioners have begun to be with rather than do for the child and family.  
  • OT practitioners can bring their "therapeutic use of self" to all team and family interactions, coaching and guiding rather than directing and doing. |
| **the family members and caregivers in a child’s life**                                 |                                                                                                                                                                                                                            |
| • EI providers engage with the adults to enhance confidence and competence in their inherent role as the people who teach and foster the child’s development  
  • Families are equal partners in the relationship with service providers  
  • Mutual trust, respect, honesty and open communication characterize the family-provider relationship |                                                                                                                                                                                                                            |
<p>| <strong>4. The early intervention process, from initial contacts through transition, must be dynamic</strong>| • We must understand each stage of the child’s emotional development in order to create effective intervention activities and to engage the parent and child in nurturing, contingent, empathic interactions. |
| <strong>and individualized to reflect the child’s and family members’ preferences, learning styles</strong>|                                                                                                                                                                                                                            |
| <strong>and cultural beliefs</strong>                                                                |                                                                                                                                                                                                                            |
| • Families are active participants in all aspects of services                           |                                                                                                                                                                                                                            |</p>
<table>
<thead>
<tr>
<th>Effective Practices</th>
<th>AOTA Position Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Families are the ultimate decision makers in the amount, type of assistance and</td>
<td>• AOTA endorses the concepts of collaboration, teamwork, and family-centered care.</td>
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<tr>
<td>the support they receive</td>
<td></td>
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<tr>
<td>• Child and family needs, interests, and skills change; the IFSP must be fluid, and</td>
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<tr>
<td>revised accordingly</td>
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<tr>
<td>• The adults in a child’s life each have their own preferred learning styles;</td>
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<tr>
<td>interactions must be sensitive and responsive to individuals</td>
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<tr>
<td>• Each family’s culture, spiritual beliefs and activities, values and traditions</td>
<td></td>
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<tr>
<td>will be different from the service provider’s (even if from a seemingly similar</td>
<td></td>
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<tr>
<td>culture); service providers should seek to understand, not judge</td>
<td></td>
</tr>
<tr>
<td>• Family “ways” are more important than provider comfort and beliefs (short of</td>
<td></td>
</tr>
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<td>abuse/neglect</td>
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<tr>
<td></td>
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<tr>
<td>5. IFSP outcomes must be functional and based on children’s and families’ needs and</td>
<td>• When developing an IFSP with a family, outcomes, for example, reflect their hopes for</td>
</tr>
<tr>
<td>priorities</td>
<td>the child’s participation in home and community life (“We want our daughter to notice</td>
</tr>
<tr>
<td>• Functional outcomes improve participation in meaningful activities</td>
<td>us”) rather than discipline-specific objectives (“Jenny will look at her parents on</td>
</tr>
<tr>
<td>• Functional outcomes build on natural motivations to learn and do; fit what’s</td>
<td>prompting three of five trials”).</td>
</tr>
<tr>
<td>important to families; strengthen naturally occurring routines; enhance natural</td>
<td>• Methods describe coaching the parent within regular family activies rather than</td>
</tr>
<tr>
<td>learning opportunities</td>
<td>exclusively therapist-child interactions.</td>
</tr>
<tr>
<td>• The family understands that strategies are worth working on because they lead to</td>
<td>• Involving the parents and other family members in the evaluation process also</td>
</tr>
<tr>
<td>practical improvements in child &amp; family life</td>
<td>establishes the importance of including them from the outset of intervention.</td>
</tr>
<tr>
<td>• Functional outcomes keep the team focused on what’s meaningful to the family in</td>
<td>• Listening to and learning from what the family has to say goes a long way toward</td>
</tr>
<tr>
<td>their day to day activities</td>
<td>designing effective early intervention for a child with disabilities.</td>
</tr>
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<td></td>
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<tr>
<td>6. The family’s priorities needs and interests are addressed most appropriately by</td>
<td>• In early intervention, a variety of team models may be utilized, including a</td>
</tr>
<tr>
<td>a primary provider who represents and receives team and community support</td>
<td>multidisciplinary, interdisciplinary, or transdisciplinary (including primary provider)</td>
</tr>
<tr>
<td>• The team can include friends, relatives, and community support people, as well as</td>
<td>approach.</td>
</tr>
<tr>
<td>specialized service providers</td>
<td>• The very nature of that which occupational therapy addresses, engagement in daily</td>
</tr>
<tr>
<td>• Good teaming practices are used</td>
<td>occupations, can be fostered in a number of ways that can be identified by the</td>
</tr>
<tr>
<td>• One consistent person needs to understand and keep abreast of the changing</td>
<td>occupational therapy practitioner and implemented on a daily basis by the family or</td>
</tr>
<tr>
<td>circumstances, needs, interests, strengths, and demands in a family’s life</td>
<td>others.</td>
</tr>
<tr>
<td>• The primary provider brings in other services and supports as needed, assuring</td>
<td>• Working as part of a transdisciplinary early intervention team in natural environments,</td>
</tr>
<tr>
<td>outcomes, activities and advice are compatible with family life and won’t</td>
<td>in which all team members’ skills merge in a unified approach, means we need not ever</td>
</tr>
<tr>
<td>overwhelm or confuse the family</td>
<td>stray far from this principle.</td>
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<td></td>
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</tbody>
</table>
### Effective Practices

<table>
<thead>
<tr>
<th>AOTA Position Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coaching should be collaborative (voluntary, mutually trusting participation between learner and coach), reflective (actively engaging in discussion and analysis with nondirective feedback), and reciprocal (shared observation resulting in two-way learning).</td>
</tr>
<tr>
<td>• In the transdisciplinary team each member works to ensure a seamless service delivery for the family through role release, reflective interactions with each other and the family, and naturally occurring learning opportunities of the natural environment.</td>
</tr>
<tr>
<td>• If occupational therapy coaching for both the parent and primary interventionist toward adapting the child’s routines to improve sensory modulation is the goal, a monthly visit may suffice.</td>
</tr>
</tbody>
</table>

### Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations

- Practices must be based on and consistent with explicit principles
- Providers should be able to provide a rationale for practice decisions
- Research is on-going and informs evolving practices
- Practice decisions must be data-based and ongoing evaluation is essential
- Practices must fit with relevant laws and regulations
- As research and practice evolve, laws and regulations must be amended accordingly

- AOTA is currently sponsoring an evidence-based literature review on occupational therapy and early intervention.
"Natural environments" is the term used in the Individuals with Disabilities Education Improvement Act, Part C (IDEA, 2004) to refer to settings that are typical for infants and toddlers without disabilities or delays. It is used as a contrast to more traditional treatment settings—such as clinical or medical-based programs—and includes families' homes, early care and education programs, and other community settings where families spend the most time with their children.

Transdisciplinary -- the emphasis on crossing disciplinary boundaries, and sharing expertise, roles, and responsibilities while recognizing the child as a whole within the context of the family (Mayhew, Scott, McWilliam, 1999; Gargiulo & Kilgo, 2000; Woodruff & McGonigel, 1988). Team members maintain a collaborative focus on functional and meaningful proficiencies within the context of the family and their day-to-day life. A primary service provider who works in close collaboration with the other team members integrates and synthesizes shared information to deliver efficient and comprehensive services. Respecting the family as a fully contributing, decision-making team member is another significant tenet of the transdisciplinary model, which reflects the highest degree of family-centeredness (Woodruff & McGonigel, 1988).

Primary Service Provider -- one professional provides weekly support to the family, backed up by a team of other professionals who provide services to the child and family through joint home visits with the primary service provider. The intensity of joint home visits depends on child, family, and primary-service-provider needs (McWilliam, 2010).

Primary Coach Approach to teaming assigns one member of a multidisciplinary team as the primary coach, where he/ she receives coaching from other team members, and uses coaching with parents and other primary caregivers to support and strengthen their confidence and competence in promoting child learning and development. A primary coach approach to teaming differs from other approaches to teaming in which one practitioner serves as the primary liaison between the family and other team members (Woodruff & McGonigel, 1988; York, Rainforth, & Giangreco, 1990) by its explicit focus on the type and content of interactions between team members and their roles for promoting parent skills, knowledge, and attributions. (This may also be referred to as primary provider.)

Functional Outcomes -- refer to things that are meaningful to the child in the context of everyday living and an integrated series of behaviors or skills that allow the child to achieve the important everyday goals.

**Sources**

American Occupational Therapy Association (AOTA)
- Side by Side: Transdisciplinary Early Intervention in Natural Environments, Kristine Ovland Pilkington, 04-03-06
- AOTA Practice Advisory on Occupational Therapy in Early Intervention, July 2010
**Family-Centered Principles** -- are a set of interconnected beliefs and attitudes that shape directions of program philosophy and behavior of personnel as they organize and deliver services to children and families. Core to family-centered services is sensitivity and respect for the culture and values of individual family members and each family's ecology, as members define the people, activities and beliefs important to them. The purpose of early intervention is to achieve family outcomes as well as child outcomes. Preschool special education services must include family involvement as well as accomplish child outcomes. Formal definitions of Family-Centered Services exist in the fields of social services, child welfare, developmental disabilities, early childhood and children's health care. While the definitions are different, there are common words and descriptions among them all. These common descriptors include: strengths based, consumer driven, family systems, family support, empowerment, proactive service delivery, promotion, competency focused, partnerships, collaborative relationships, family driven (Pletcher & McBride, 2003).

**Medical Home** -- AAP describes the Pediatric Medical Homes: Laying the Foundation of a Promising Model of Care medical home as, “a model of delivering primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.” Once identified, children with special health care needs (CSHCN) require a medical home: a source of ongoing routine health care in their community where providers and families work as partners to meet the needs of children and families. The medical home assists in the early identification of special health care needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services.

**Role Release** -- team members put newly acquired techniques into practice under the supervision of team members from the discipline that has accountability for those practices.

**Teaming** -- interventionists practice role release and role expansion. Regularly scheduled team meetings and consultations provide opportunities for exchange of information and training for the whole team. All members support the primary service provider.

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Key Principles of Early Intervention and Effective Practices: A Crosswalk with the American Physical Therapy Association Position Statements
This document is a comprehensive outcome of technical assistance provided to state Part C programs in the Mountain Plains Region. Many states have been evaluating their early intervention practices and undergoing system change to incorporate Effective Practices related to providing services within the natural environment and implementing a primary service provider approach. Currently over 50% of states are utilizing the primary service provider approach to early intervention. This document is an effort to capture effective early intervention practices and position statements from the ARC of the United States (ARC) and the American Association on Intellectual and Developmental Disabilities (AAIDD) into one document.

The starting point was the document AGREED UPON PRACTICES FOR PROVIDING EARLY INTERVENTION SERVICES IN NATURAL ENVIRONMENTS, listing the concepts underlying the brief statements. The document, developed by the Workgroup on Principles and Practices in Natural Environments, reflects practices validated through multiple research, model demonstration and outreach projects implemented by work group members. The practices reflect consensus opinion of the work group members who avoided endorsing any specific practice model or approach. The practices suggest a flow of activities that need to occur during the IFSP process from first contacts through transition, and are not intended to be used as a sequential “checklist”. The readers should be advised that there will be variations in implementation due to state and local procedures.


Citations:

The principles identified in this document were cross walked with a statement from the ARC and AAIDD that provide support to early intervention services. States may find this document useful for comparing the agreed upon practices for early intervention with the ARC and AAIDD position statement. In some instances the ARC and AAIDD may use different terms to refer to practices. This document reflects statements by the ARC AAIDD, but is not attributing meaning to those statements. At the end of the document is a web link to the paper utilized in creating this document and also a glossary to ensure a common understanding of terms.
# Effective Practices

1. **Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts**
   - Learning activities and opportunities must be functional, based on child and family interest and enjoyment
   - Learning is relationship-based
   - Learning should provide opportunities to practice and build upon previously mastered skills
   - Learning occurs through participation in a variety of enjoyable activities

2. **All families, with the necessary supports and resources, can enhance their children’s learning and development**
   - All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources)
   - The consistent adults in a child’s life have the greatest influence on learning and development—not EI providers
   - All families have strengths and capabilities that can be used to help their child
   - All families are resourceful, but all families do not have equal access to resources
   - Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities

3. **The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child’s life**
   - EI providers engage with the adults to enhance confidence and competence in their inherent role as the people who teach and foster the child’s development
   - Families are equal partners in the relationship with service providers
   - Mutual trust, respect, honesty and open communication characterize the family-provider relationship

4. **The early intervention process, from initial contacts through transition, must be dynamic**

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### APTA Position Statements

- Natural environments are home (family life) and community-life settings that are natural and typical for children without a disability and their families.
- Settings where the child, family, and care providers participate in everyday routines and activities that are important to them and serve as important learning opportunities.
- Support families in promoting their children’s development, learning, and participation in family and community life.
- The choice of team approach should be based on the needs of the child and family:
  - A shared framework of trust.
  - Clearly defined roles and responsibilities.
  - Respectful and empathetic open communication.
- Provide families with emotional, informational, and material resources to support the achievement of Individualized Family Service Plan (IFSP) outcomes.
- According to Chiarello and Kolobe, “team collaboration is the process of forming partnerships among family members, service providers, and the community with the common goal of enhancing the child’s development and supporting the family.”
- Invite and encourage families and care providers to identify
<table>
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<tbody>
<tr>
<td>and individualized to reflect the child’s and family members’ preferences, learning styles and cultural beliefs</td>
<td>their priorities and outcomes as an initial step in the planning process.</td>
</tr>
<tr>
<td>• Families are active participants in all aspects of services</td>
<td>• Strengthen and develop lifelong natural supports for children and families.</td>
</tr>
<tr>
<td>• Families are the ultimate decision makers in the amount, type of assistance and the support they receive</td>
<td>• Recognize family members and care providers as the primary influence for nurturing growth, development, and learning.</td>
</tr>
<tr>
<td>• Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly</td>
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<td>• The adults in a child’s life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals</td>
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<td>• Each family’s culture, spiritual beliefs and activities, values and traditions will be different from the service provider’s (even if from a seemingly similar culture); service providers should seek to understand, not judge</td>
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<td>• Family “ways” are more important than provider comfort and beliefs (short of abuse/neglect)</td>
<td></td>
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<tr>
<td>5. IFSP outcomes must be functional and based on children’s and families’ needs and priorities</td>
<td>• Emphasize children’s, families’, and care providers’ abilities during everyday activities, rather than teaching a new skill out of context.</td>
</tr>
<tr>
<td>• Functional outcomes improve participation in meaningful activities</td>
<td>• Provide physical therapy within the context of family and child routines and activities.</td>
</tr>
<tr>
<td>• Functional outcomes build on natural motivations to learn and do; fit what’s important to families; strengthen naturally occurring routines; enhance natural learning opportunities</td>
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<td></td>
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<tr>
<td>6. The family’s priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support</td>
<td>• The choice of team approach should be based on the needs of the child and family. There has been a recent shift toward the recommendation and use of transdisciplinary teaming, particularly in early intervention settings.</td>
</tr>
<tr>
<td>• The team can include friends, relatives, and community support people, as well as specialized service providers</td>
<td>• When a team functions in a transdisciplinary fashion, the primary provider can change as the child’s and family’s needs change. In this team approach, physical therapists share aspects of their discipline and learn aspects of other team members’ disciplines.</td>
</tr>
<tr>
<td>• Good teaming practices are used</td>
<td>• Role release was described by Lyon and Lyon as the deliberate process of sharing information and skills and was conceptualized as occurring across multiple levels.</td>
</tr>
<tr>
<td>• One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family’s life</td>
<td>• It is important that the family and other team members understand that when performing the activities that the</td>
</tr>
<tr>
<td>Effective Practices</td>
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</table>
| physical therapist taught them, they are implementing specific activities to support their child’s development, not providing physical therapy.  
- Within the transdisciplinary approach, Rush, Shelden, and Hanft describe a primary coach approach to teaming where a single, long-term service provider is assigned as the primary coach to the family or caregivers.  
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations  
- Practices must be based on and consistent with explicit principles  
- Providers should be able to provide a rationale for practice decisions  
- Research is on-going and informs evolving practices  
- Practice decisions must be data-based and ongoing evaluation is essential  
- Practices must fit with relevant laws and regulations  
- As research and practice evolve, laws and regulations must be amended accordingly  
- Physical therapists apply the latest research related to restoring function, reducing pain, and preventing injury.  
- Hooked on Evidence is APTA’s "grassroots" effort to develop a database containing current research evidence and clinical scenarios on the effectiveness of physical therapy interventions. |

**SOURCES**

**American Physical Therapy Association (APTA)**  
- *Natural Environments in Early Intervention*, Practice Committee of the Section on Pediatrics, APTA, 2008  
- *Integrating Therapy into the Classroom*, National Individualizing Preschool Inclusion Project, R A McWilliam, Stacy Scott, August 2003  
"Natural environments" is the term used in the Individuals with Disabilities Education Improvement Act, Part C (IDEA, 2004) to refer to settings that are typical for infants and toddlers without disabilities or delays. It is used as a contrast to more traditional treatment settings—such as clinical or medical-based programs—and includes families' homes, early care and education programs, and other community settings where families spend the most time with their children.

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</table>
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  - Learning activities and opportunities must be functional, based on child and family interest and enjoyment  
  - Learning is relationship-based  
  - Learning should provide opportunities to practice and build upon previously mastered skills  
  - Learning occurs through participation in a variety of enjoyable activities  | - Services are developmentally supportive and promote children’s participation in their natural environments.  
  - Early speech and language skills are acquired and used primarily for communicating during social interactions.  
    - ... intervention occurring within the child's and family's functional and meaningful routines.  
    - ... services and supports—including speech-language and audiology treatment—are provided in the locations where the families typically spend their time.  
  - Children learn through participating in their everyday activities and meaningful experiences with their family and caregivers. |
| 2. **All families, with the necessary supports and resources, can enhance their children’s learning and development**  
  - All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources)  
  - The consistent adults in a child’s life have the greatest influence on learning and development—not EI providers  
  - All families have strengths and capabilities that can be used to help their child  
  - All families are resourceful, but all families do not have equal access to resources  
  - Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities  | - Children learn through participating in their everyday activities and meaningful experiences with their family and caregivers. When caregivers maximize learning opportunities in the child’s daily routines and activities, the child has many opportunities for intervention every day, throughout the day, and in a meaningful and responsive manner.  
  - Anchors for learning are plentiful when the family or caregiver participates in identifying opportunities to embed different intervention strategies or outcomes.  
  - Help parents and caregivers to build competence by using instructional techniques that build their confidence.  
  - Confidence and motivation will grow from success in embedding intervention, improvement in the child’s skills, and positive experiences with the consulting process. |
| 3. **The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child’s life**  
  - EI providers engage with the adults to enhance confidence and competence in their inherent role  | - Families provide a lifelong context for a child's development and growth. |
<table>
<thead>
<tr>
<th>Effective Practices</th>
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<tbody>
<tr>
<td>• as the people who teach and foster the child’s development</td>
<td>• The family, rather than the individual child, is the primary recipient of services to the extent desired by the family.</td>
</tr>
<tr>
<td>• Families are equal partners in the relationship with service providers</td>
<td>• Young children learn through familiar, natural activities, it is important for the SLP to provide information that promotes the parents' and/or other caregivers' abilities to implement communication-enhancing strategies during those everyday routines, creating increased learning opportunities and participation for the child.</td>
</tr>
<tr>
<td>• Mutual trust, respect, honesty and open communication characterize the family-provider relationship</td>
<td>• The SLP shares information and resources, and coaches the parents about including communication activities throughout the child’s day, with content individualized to meet the specific needs of the child.</td>
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<td>• The family, rather than the individual child, is the primary recipient of services to the extent desired by the family.</td>
<td>• SLPs should look for ways to join in the caregiver-child interactions, rather than expecting the caregiver to observe or join the SLP-child activities.</td>
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4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child’s and family members’ preferences, learning styles and cultural beliefs

• Families are active participants in all aspects of services
• Families are the ultimate decision makers in the amount, type of assistance and the support they receive
• Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly
• The adults in a child’s life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals
• Each family’s culture, spiritual beliefs and activities, values and traditions will be different from the service provider’s (even if from a seemingly similar culture); service providers should seek to understand, not judge
• Family “ways” are more important than provider comfort and beliefs (short of abuse/neglect)

• Services Are Family-Centered and Culturally Responsive: An aim of all early intervention services and supports is responsiveness to family concerns for each child’s strengths, needs, and learning styles.
• An important component of individualizing services includes the ability to align services with each family’s culture and unique situation, preferences, resources, and priorities.

5. IFSP outcomes must be functional and based on children’s and families’ needs and priorities

• Functional outcomes improve participation in meaningful activities
• Functional outcomes build on natural motivations to learn and do; fit what’s important to families; strengthen naturally occurring routines; enhance natural learning opportunities
• The family understands that strategies are worth working on because they lead to practical improvements in child & family life

• Consultative and collaborative models are closely aligned with inclusive practices; involve services delivered in natural environments, and focus on functional communication during the child and family's natural daily activities and routines.
• Functional and meaningful child communication goals reflecting the family’s priorities are critical.
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<td>• Functional outcomes keep the team focused on what’s meaningful to the family in their day to day activities</td>
<td>• A thorough exploration of the caregiver's objectives for the child will enhance the development of goals for consultation and lead to clear, relevant, and jointly established expectations.</td>
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<td>• Agreeing upon the learning priorities promotes collaboration.</td>
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<td><strong>6. The family’s priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support</strong></td>
<td>• A transdisciplinary model typically includes some type of “role release” of one professional to another and is sometimes implemented as a primary provider model.</td>
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<tr>
<td>• The team can include friends, relatives, and community support people, as well as specialized service providers</td>
<td>• The use of transdisciplinary models with a primary service provider may be appropriate for SLPs.</td>
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<td>• Good teaming practices are used</td>
<td>• Teams benefit from joint professional development and also can enhance each other's knowledge and skills through role extension and role release for specific children and families.</td>
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<td>• One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family’s life</td>
<td>• SLPs may serve as either primary providers or consultants in transdisciplinary models, and should be considered for the primary provider role when the child's main needs are communication or feeding and swallowing.</td>
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<td>• The primary provider brings in other services and supports as needed, assuring outcomes, activities and advice are compatible with family life and won’t overwhelm or confuse family members</td>
<td>• In some instances, one professional on the team is designated as the primary service provider (PSP); this model helps avoid fragmentation of services and frequent home visits from multiple professionals.</td>
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<td>• When using the PSP model, the team must communicate regularly to support one another—as well as the child and family—to ensure maximum progress.</td>
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<td>• The designation of the PSP should be a team decision and individualized for each child and family.</td>
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<td><strong>7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations</strong></td>
<td>• The ASHA Position Paper document includes conclusions and recommendations derived from available empirical evidence that were formed by consensus of the ASHA Ad Hoc Committee on the Role of the Speech-Language Pathologist in Early Intervention through five face-to-face meetings and</td>
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## Effective Practices

- Research is on-going and informs evolving practices
- Practice decisions must be data-based and ongoing evaluation is essential
- Practices must fit with relevant laws and regulations
- As research and practice evolve, laws and regulations must be amended accordingly

## ASHA Position Statements

- nine phone conferences between November 2004 and December 2007.
- SLPs recognize that in areas for which empirical evidence is lacking, extrapolations from evidence with other populations and applications of principles stemming from theoretical models, societal norms, and government mandates and regulations also are relevant for decision making.
- Services are based on the highest quality internal and external evidence that is available: Early intervention practices are based on an integration of the highest quality and most recent research, informed professional judgment and expertise, and family preferences and values.
- Research about service delivery models in early intervention is in an emerging phase, and as a result, some practices may be based more on policy and professional and family preferences than on theories or research.

### SOURCES

**American Speech-Language-Hearing Association (ASHA)**
- March 25, 2008 Feature *Providing Early Intervention Services in Natural Environments* by Juliann Woods
GLOSSARY

"Natural environments" is the term used in the Individuals with Disabilities Education Improvement Act, Part C (IDEA, 2004) to refer to settings that are typical for infants and toddlers without disabilities or delays. It is used as a contrast to more traditional treatment settings—such as clinical or medical-based programs—and includes families' homes, early care and education programs, and other community settings where families spend the most time with their children.

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<td>- Providing access to a wide range of learning opportunities, activities, settings, and environments is a defining feature of high quality early childhood inclusion.</td>
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<td>- Opportunities for learning in the child’s natural settings must be identified including the learning opportunities that occur in those settings.</td>
</tr>
<tr>
<td>- More active involvement of parents in their child’s program appears to be related to greater developmental progress.</td>
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<td>- Regular caregivers and regular routines provide the most appropriate opportunities for children’s learning and receiving most other interventions.</td>
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<td>- Young children learn through ongoing interactions with their natural environment rather than in isolated lessons or sessions.</td>
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<th>2. All families, with the necessary supports and resources, can enhance their children’s learning and development</th>
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<td>- All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources)</td>
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<td>- The consistent adults in a child’s life have the greatest influence on learning and development—not EI providers</td>
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<td>- All families have strengths and capabilities that can be used to help their child</td>
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<td>- All families are resourceful, but all families do not have equal access to resources</td>
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<td>- Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities</td>
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| Family-based practices provide or mediate the provision of resources and supports necessary for families to have the time, energy, knowledge and skills to provide their children learning opportunities and experiences that promote child competence and development. |
| Professionals must strengthen families’ abilities to support the development of their children in a manner that is likely to increase families’ sense of parenting competence, not families’ sense of dependency on professionals or professional systems. |
| Interventions must be based on the strengths and assets of children, parents and the family in order to have optimal benefits and outcomes. |

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<th>3. The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child’s life</th>
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<p>| Families are the constant in a child’s life, thus practices should honor and facilitate the family’s caregiving and decision-making roles. |
| Families or parents are considered central and the most important decision maker in a child’s life. |</p>
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<td>• Mutual trust, respect, honesty and open communication characterize the family-provider relationship</td>
<td>• Family members, practitioners, specialists, and administrators should have access to ongoing professional development and support to acquire the knowledge, skills, and dispositions required to implement effective inclusive practices.</td>
</tr>
<tr>
<td>• Mutual trust, respect, honesty and open communication characterize the family-provider relationship</td>
<td>• Recognizing the central role of the family, providers, agencies and family members must work together as a team rather than as individuals.</td>
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4. **The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child’s and family members’ preferences, learning styles and cultural beliefs**
   - Families are active participants in all aspects of services
   - Families are the ultimate decision makers in the amount, type of assistance and the support they receive
   - Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly
   - The adults in a child’s life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals
   - Each family’s culture, spiritual beliefs and activities, values and traditions will be different from the service provider’s (even if from a seemingly similar culture); service providers should seek to understand, not judge
   - Family “ways” are more important than provider comfort and beliefs (short of abuse/neglect)

   • Respect for all children and families is a fundamental value supported by DEC.
   • Teachers and others who work with and on behalf of children and families must respect, value, and support the culture, values, and languages of each home and promote the active participation of all families.
   • Practitioners’ use ongoing data to individualize and adapt practices to meet each child’s changing needs.

5. **IFSP outcomes must be functional and based on children’s and families’ needs and priorities**
   - Functional outcomes improve participation in meaningful activities
   - Functional outcomes build on natural motivations to learn and do; fit what’s important to families; strengthen naturally occurring routines; enhance natural learning opportunities
   - The family understands that strategies are worth working on because they lead to practical improvements in child & family life
   - Functional outcomes keep the team focused on what’s meaningful to the family in their day to day activities

   • Team members focus on the individual child’s functioning (e.g. engagement, independence, social relationships) in the contexts in which he or she lives not the service.
   • Functionality is stressed to ensure that children receive intervention aimed at valued outcomes or outcomes that matter in their daily lives.

6. **The family’s priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support**
   - The team can include friends, relatives, and community support people, as well as specialized service providers.
   - Good teaming practices are used

   • Transdisciplinary model of service delivery is recommended to avoid fracturing (or segregating) services along disciplinary lines.
   • A critical value embedded in transdisciplinary practices is the
### Effective Practices

- One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family’s life
- The primary provider brings in other services and supports as needed, assuring outcomes, activities and advice are compatible with family life and won’t overwhelm or confuse family members

### DEC/NAEYC Position Statements

- exchange of competencies between team members.

### 7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations

- Practices must be based on and consistent with explicit principles
- Providers should be able to provide a rationale for practice decisions
- Research is on-going and informs evolving practices
- Practice decisions must be data-based and ongoing evaluation is essential
- Practices must fit with relevant laws and regulations
- As research and practice evolve, laws and regulations must be amended accordingly

- DEC Recommended Practices have two primary goals to:
  - Produce an empirically supported set of recommendations for practice with young children with disabilities birth through age 5, their families, and those who work with them.
  - To increase the likelihood of the use and adoption of the Recommended Practices by identifying “indirect supports” necessary for improving direct service practice.

- Practices are supported by research evidence; experience and values of stakeholders and field validation.

- The field now has a good deal of research for guiding Practitioners’ decisions related to organizing and influencing children’s experiences.

### SOURCE

Division for Early Childhood (DEC) [www.dec-sped.org](http://www.dec-sped.org) and National Association for the Education of Young Children (NAEYC) [http://www.naeyc.org/](http://www.naeyc.org/)

- Early Childhood Inclusion A Joint Position Statement of the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC)
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### NASP Position Statements

- We must work with school administrators, teachers, and families to develop comprehensive intervention programs that are developmentally appropriate, family centered, and sensitive to cultural and linguistic differences.

<table>
<thead>
<tr>
<th>4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child’s and family members’ preferences, learning styles and cultural beliefs</th>
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<tbody>
<tr>
<td>• Families are active participants in all aspects of services</td>
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<tr>
<td>• Families are the ultimate decision makers in the amount, type of assistance and the support they receive</td>
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<td>• Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly</td>
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<tr>
<td>• The adults in a child’s life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals</td>
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<tr>
<td>• Each family’s culture, spiritual beliefs and activities, values and traditions will be different from the service provider’s (even if from a seemingly similar culture); service providers should seek to understand, not judge</td>
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### NASP Position Statements

- Cultural differences between service providers and families must be recognized.
- Practitioners must be aware that families’ communication styles, belief systems, and perceptions of disability, may vary greatly from their own.
- Provide advocacy and leadership in building comprehensive, collaborative systems of care that value parents as equal partners, respect individual differences and incorporate multicultural perspectives while insuring access to high-quality early educational environments for all young children.
<table>
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<tr>
<th><strong>Effective Practices</strong></th>
<th><strong>NASP Position Statements</strong></th>
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<tbody>
<tr>
<td>• Family “ways” are more important than provider comfort and beliefs (short of abuse/neglect)</td>
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<tr>
<td>5. <strong>IFSP outcomes must be functional and based on children’s and families’ needs and priorities</strong></td>
<td>• Developmentally appropriate practices take into account what is known about child development and learning, what is known about the unique needs, strengths and interests of each child, and what is known about the cultural and social environments in which each child lives.</td>
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<tr>
<td>• Functional outcomes improve participation in meaningful activities</td>
<td>• Parents should be encouraged to target goals for their child, learn about their legal rights and responsibilities and exchange information with providers.</td>
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<tr>
<td>• Functional outcomes build on natural motivations to learn and do; fit what’s important to families; strengthen naturally occurring routines; enhance natural learning opportunities</td>
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<tr>
<td>• The family understands that strategies are worth working on because they lead to practical improvements in child &amp; family life</td>
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<tr>
<td>• Functional outcomes keep the team focused on what’s meaningful to the family in their day to day activities</td>
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<tr>
<td>6. <strong>The family’s priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support</strong></td>
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<tr>
<td>• The team can include friends, relatives, and community support people, as well as specialized service providers</td>
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<tr>
<td>• Good teaming practices are used</td>
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<tr>
<td>• One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family’s life</td>
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<tr>
<td>• The primary provider brings in other services and supports as needed, assuring outcomes, activities and advice are compatible with family life and won’t overwhelm or confuse family members</td>
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<tr>
<td>7. <strong>Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations</strong></td>
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<tr>
<td>• Practices must be based on and consistent with explicit principles</td>
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<tr>
<td>• Providers should be able to provide a rationale for practice decisions</td>
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<tr>
<td>• Research is on-going and informs evolving practices</td>
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<tr>
<td>• Practice decisions must be data-based and ongoing evaluation is essential</td>
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<tr>
<td>• Practices must fit with relevant laws and regulations</td>
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<tr>
<td>• As research and practice evolve, laws and regulations must be amended accordingly</td>
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<tr>
<td>• NASP encourages the use of empirically based, culturally sensitive, developmentally appropriate practices that are implemented in the child’s natural environment whenever possible.</td>
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<tr>
<td>• Ideally, the school psychologist must work in unison with other early childhood intervention professionals to ensure that programs are based on methods with solid empirical support.</td>
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<tr>
<td>• Utilize research from areas of child development, developmental psychopathology, risk and resilience, and disability prevention to promote adoption of empirically demonstrated instructional practices in areas such as emergent literacy, socialization and problem-solving skills and self-management.</td>
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</table>
SOURCE

National Association of School Psychologists (NASP)
- *NASP Position Statement on Early Intervention Services*, Revision adopted by NASP Delegate Assembly, April 12, 2003
  [http://caspsurveys.org/NEW/pdfs/nasp01.pdf](http://caspsurveys.org/NEW/pdfs/nasp01.pdf)

GLOSSARY

"Natural environments" is the term used in the Individuals with Disabilities Education Improvement Act, Part C (IDEA, 2004) to refer to settings that are typical for infants and toddlers without disabilities or delays. It is used as a contrast to more traditional treatment settings—such as clinical or medical-based programs—and includes families' homes, early care and education programs, and other community settings where families spend the most time with their children.

Transdisciplinary -- the emphasis on crossing disciplinary boundaries, and sharing expertise, roles, and responsibilities while recognizing the child as a whole within the context of the family (Mayhew, Scott, McWilliam, 1999; Gargiulo & Kilgo, 2000; Woodruff & McGonigel, 1988). Team members maintain a collaborative focus on functional and meaningful proficiencies within the context of the family and their day-to-day life. A primary service provider who works in close collaboration with the other team members integrates and synthesizes shared information to deliver efficient and comprehensive services. Respecting the family as a fully contributing, decision-making team member is another significant tenet of the transdisciplinary model, which reflects the highest degree of family-centeredness (Woodruff & McGonigel, 1988).

Primary Service Provider -- one professional provides weekly support to the family, backed up by a team of other professionals who provide services to the child and family through joint home visits with the primary service provider. The intensity of joint home visits depends on child, family, and primary-service-provider needs (McWilliam, 2010).

Primary Coach Approach to teaming assigns one member of a multidisciplinary team as the primary coach, where he/she receives coaching from other team members, and uses coaching with parents and other primary caregivers to support and strengthen their confidence and competence in promoting child learning and development. A primary coach approach to teaming differs from other approaches to teaming in which one practitioner serves as the primary liaison between the family and other team members (Woodruff & McGonigel, 1988; York, Rainforth, & Giangreco, 1990) by its explicit focus on the type and content of interactions between team members and their roles for promoting parent skills, knowledge, and attributions. (This may also be referred to as primary provider.)

Functional Outcomes -- refer to things that are meaningful to the child in the context of everyday living and an integrated series of behaviors or skills that allow the child to achieve the important everyday goals.
Family-Centered Principles -- are a set of interconnected beliefs and attitudes that shape directions of program philosophy and behavior of personnel as they organize and deliver services to children and families. Core to family-centered services is sensitivity and respect for the culture and values of individual family members and each family's ecology, as members define the people, activities and beliefs important to them. The purpose of early intervention is to achieve family outcomes as well as child outcomes. Preschool special education services must include family involvement as well as accomplish child outcomes. Formal definitions of Family-Centered Services exist in the fields of social services, child welfare, developmental disabilities, early childhood and children's health care. While the definitions are different, there are common words and descriptions among them all. These common descriptors include: strengths based, consumer driven, family systems, family support, empowerment, proactive service delivery, promotion, competency focused, partnerships, collaborative relationships, family driven (Pletcher & McBride, 2003).

Medical Home -- AAP describes the Pediatric Medical Homes: Laying the Foundation of a Promising Model of Care medical home as, “a model of delivering primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.” Once identified, children with special health care needs (CSHCN) require a medical home: a source of ongoing routine health care in their community where providers and families work as partners to meet the needs of children and families. The medical home assists in the early identification of special health care needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services.

Role Release -- team members put newly acquired techniques into practice under the supervision of team members from the discipline that has accountability for those practices.

Teaming -- interventionists practice role release and role expansion. Regularly scheduled team meetings and consultations provide opportunities for exchange of information and training for the whole team. All members support the primary service provider.

RRCP Early Childhood Service Delivery Priority Team provided review and technical assistance to this document. Members of the team included Betsy Ayankoya, Sharon Ringwalt, Ann Bailey, Sharon Walsh, Sue Goode, Joicy Hurth, Anne Lucas, Karen Mikkelson, and Lynda Pletcher.

This paper was crafted by Wendy Whipple, who served as the primary author. Before it was finalized, Wendy died suddenly of a massive stroke. Anne Lucas and Betsy Ayankoya picked up the work and completed the final editing. This paper is dedicated to the memory of Wendy, who dedicated her life to advocating for providing the highest quality service for the benefit of children.