Making Best Practice Our Practice

Reflections on Our Journey Into Natural Environments

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This article focuses on one early intervention team’s transition from a multidisciplinary center-based model to a transdisciplinary, natural environment service delivery model. The team consisted of an occupational therapist, physical therapist, speech and language pathologist, and early intervention teacher. Each team member began with different backgrounds, skill sets, and beliefs about how early intervention services should look. The team agreed upon basic principles of best practice for early intervention, but the level of comfort for implementation varied greatly among team members. Over the last 2 years, the team has learned about themselves and the art of delivering family-centered practice to families with young children with disabilities. This is a reflection on 6 lessons learned as they moved out of the classroom where equipment, materials, and physical surroundings defined services and determined roles, and moved into the homes of the families where services and roles were ever-changing and unpredictable. Finally, implications for personnel preparation, including professional development and preservice training programs, are discussed.

Key words: early intervention, natural environments, primary service provider, professional preparation, transdisciplinary

EARLY INTERVENTION SERVICE PROVIDER: First visits are always so in-tense. As I prepared for this initial visit, I eyed the toys and materials on the floor of the car, toys that had been useful when I provided services at school but which I wasn’t supposed to use during this visit. Could I do my job without them? Would I be able to support this family in preparing their infant for the future? I worried that I might not have the skills this family needed. What if time dragged on, or they had questions I couldn’t answer? What if the baby cried the whole time? What if I couldn’t move things in the direction that was best for this infant? I took a deep breath as I walked to the house. I secretly hoped the mother would turn me away and reschedule for another day. I hesitantly knocked on the door.

The mission of early intervention services as mandated by Part C of the Individuals with Disabilities Education Act is as follows: “early intervention builds upon and provides...”
supports and resources to assist family members and caregivers to enhance children’s learning and development through everyday learning opportunities” (Workgroup on Principles and Practices in Natural Environments, 2007, p. 2). Early intervention facilitates the participation of infants and toddlers with disabilities in family and community activities by serving children in natural environments as mandated by IDEA regulations (34 CFR 303.167). The natural environment requirement is supported by professional organizations such as The Division for Early Childhood of the Council for Exceptional Children (DEC). The Division for Early Childhood of the Council for Exceptional Children recommends that services delivered to young children occur in environments where “typical children participate such as the home or community setting” (Sandall, Hemmeter, Smith, & McLean, 2005, p. 82).

There are many models and practices for delivering early intervention. One recommended framework for early intervention service delivery is the Primary Service Provider (PSP) model (McWilliam, 2010). According to McWilliam (2010), the primary service provider model occurs when one main professional provides support and services to the child and family. Other professionals support the PSP and/or the family through joint visits and collaboration. This model allows children and families to form a relationship with one versus several professionals (Vanderhoff, 2004). For a PSP model to be effective, teams must be transdisciplinary (Bruder, 2010; McWilliam, 2010). Transdisciplinary teaming involves a group of professionals with various areas of expertise, crossing disciplinary boundaries to address the developmental concerns of children and their families’ needs for support. The primary service provider is the family’s main contact and uses strategies other team members provide; however, every team member is familiar with all children and any team member may have direct contact if necessary (McWilliam, 2010). An intense level of support from and between team members is a fundamental component for success, particularly when services occur within the natural environment.

Part C services are delivered through the State Education Agency in Michigan. In Oakland County, a large suburban county north of Detroit, there are 28 local education agencies responsible for providing early intervention services to young children who live within their geographic boundaries. Services are individualized on the basis of the needs of the child and family, but also as a result of how each of the local districts organizes and implements the delivery model. Historically, one specific local school district provided early intervention services through a classroom model. Parents brought their children to school for 1 hr, 2–3 times a week. An early intervention teacher, speech and language therapist, occupational therapist, and physical therapist delivered services to approximately 60 children each year. The purpose of the parent–child group was to provide a developmentally appropriate learning environment for young children to address their educational goals, with assistance from a multidisciplinary team of interventionists. Staff believed this model was aligned with one of the main purposes of early intervention—to enhance the capacity of families to meet the special needs of their children with disabilities—because parents were in the classroom with their children. The following vignette describes an example of an experience of a family and child.

Bella’s mother would usually bring Bella to school twice a week, when Bella was healthy enough to attend. She would try to ask questions about Bella specifically. However, since the other eight families had so many questions about their children, she often struggled with what and when to ask. Bella’s mom noticed that Bella seemed to eat her snack better using special equipment and strategies, but she was not sure how to replicate these strategies at home. Bella would get sick very easily, and her mom was worried she would get a cold at school. When surgery was scheduled, Bella would often miss her early intervention service to
ensure that she did not get a cold. If she did come to school and get sick, not only would she miss surgery, she would lose the weight the family worked so hard for her to gain.

As staff studied recommended practices from experts in the field of early intervention, they began to question their existing service delivery model. They suspected that a primary service provider model, which emphasized transdisciplinary work in natural environments, would better meet children’s and families’ needs. Yet, adopting this model required rethinking professional roles and obtaining administrative support. The decision was made to leave behind the multidisciplinary classroom model and move toward providing early intervention in natural environments using primary service providers. This was a significant shift in practice. Reflecting on this process over the last 18 months, the team has identified six lessons that will help others interested in improving their practice with infants, toddlers, and families. In addition, the team identified practical strategies for implementing each lesson (Table 1).

**LESSON 1: THE NATURAL ENVIRONMENT IS NOT A PLACE**

One might assume that “natural environment” refers specifically to a place, such as a child’s home. However, natural environment involves much more than the location of services. Natural environment is a thought process or a way of doing business. It refers to intervention that is contextually relevant to the child and family (Dunst, Trivette, Humphries, Raab, & Roper, 2001). When working within the child’s natural environment, intervention strategies can be designed to fit into the daily routines of families. Furthermore, strategies that are developed in conjunction with parents, to meet the needs of the family and child in their “natural environment,” are more likely to be used consistently throughout the day (ERIC/OSEP Special Projects, 2001; Woods & Kashinath, 2007). Positive outcomes for children have been shown when intervention is delivered within the context of the family’s daily routine (Dunst, Bruder, Trivette, & Hamby, 2006; McWilliam & Scott, 2001).

Providing services in the natural environment does not mean that we wrap up the classroom or therapy room and bring it to the family. Services provided in the natural environment are not “take-out service.” Children develop and learn best within the context of their families. In the home, we can show parents that daily living activities provide children opportunities to embed learning throughout their day. A child will pull to stand repeatedly when a sibling is hidden behind the sofa. Offering two favorite toys increases the likelihood that a child will identify a choice. The number of times a family participates in a given activity drives the frequency of intervention. For example, Will was working on crawling; we used a tunnel with his favorite car placed at the end to encourage him to move through the tunnel. On the next visit, mom reported that she used the tunnel to work on balance and strengthening his upper body by placing the tunnel over Will while he was sitting. Mom showed me how he would slowly lower himself to the ground and work on falling over with the tunnel around him. He was able to reach over his head and compress the tunnel to play a game of hide and seek while strengthening his trunk and shoulders. Clearly, mom knew what her son needed and adapted activities to meet his needs.

Additionally, we have discovered unexpected benefits while working in natural environments. Parents appreciate that there are no comparisons of their child’s behavior or skills against similar aged children when services occur at home. There is no audience present, just an opportunity for people working with one child toward the same goal. Parents of medically fragile children report relief being at home with their child, where they can limit their exposure to elements that would further compromise their delicate health. When we are in the home, the most important topic and the greatest needs to address are those of the family whose living room floor on which we are seated. This
Table 1. Practical Strategies for Each Lesson

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<thead>
<tr>
<th>Lesson</th>
<th>Guiding Principle</th>
<th>Strategies for Effective Practice</th>
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<tbody>
<tr>
<td>Lesson 1: Natural environment is not a place</td>
<td>Services are provided where daily routines can be observed and positively impacted</td>
<td>Any family member—from young to old—can be part of the support team, as well as neighbors, friends, and pets. Go outside. There are many options for working on strength, balance, motor, and sensory experiences. Make small changes in the home. Place a baby gate at the second step to allow for safe practice of climbing up and down the stairs.</td>
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<td>Lesson 2: The magic is not in the bag</td>
<td>Materials to support successful participation in daily routines are those readily available to parents</td>
<td>Use items in the home as intervention tools. For example, get out the family photo albums to encourage language, pointing, and observing family routines. Repurpose household materials. A sheet becomes a parachute, an indoor slip and slide, a magic carpet, a peek-a-boo prop, or an indoor swing.</td>
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<td>Lesson 3: Parents are the key</td>
<td>The primary purpose of early intervention is to improve family’s abilities to support their child’s growth and development</td>
<td>Be sure that there are clear expectations about participating in early intervention for staff and families. Provide information in multiple ways so that families are clear about the intent. Model interventions, then allow parents to practice and provide feedback. Use technology in conjunction with print materials to support families. Videos and photo are wonderful tools that are simple to use.</td>
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<td>Lesson 4: Respect family norms and values</td>
<td>Build support around culturally acceptable practices</td>
<td>Set aside time to maintain communication through the family’s preferred mode, e-mail, text, phone calls, etc. Look for the good in all families and situations. There is no one example of the “perfect family.” Treat the family and their home with respect. Be on time and prepared. Be a gracious visitor.</td>
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<td>Lesson 5: Leave your title at the door</td>
<td>Team functions as early interventionists with varying skills and expertise on the basis of our background and experiences</td>
<td>Introduce yourself as an “early interventionist” to help parents understand the transdisciplinary model.</td>
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Table 1. Practical Strategies for Each Lesson (Continued)

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<td>Lesson 6: Take time to reflect</td>
<td>Reflective practice allows staff to step back, individually and with others, to analyze what works and why</td>
<td>Leave information for families that is user friendly, free of jargon, and incorporates family routines. Meet weekly with colleagues to share experiences, brainstorm, and problem solve. Use the drive time between visits to think about what went well and what could have been different. Keep notes, start a journal, and talk with colleagues. Establish a support network of coworkers. Talk to coworkers during meeting times or after joint home visits, eat lunch with a mentor, seek out an administrator who can function as a coach. Gather honest feedback about how things are going. Talk face-to-face and use surveys, questionnaires, and reviews.</td>
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Undivided attention is of great comfort and support to families.

LESSON 2: THE MAGIC IS NOT IN THE BAG

Intervention should build upon children’s interests and focus on caregivers as primary teachers (Dunst et al., 2001; ERIC/OSEP Special Projects, 2001; McWilliam, 2000; Sandall et al., 2005; Woods & Kashinath, 2007; Woods, Kashinath, & Goldstein, 2004). Embedding learning and intervention opportunities into daily activities allows children to learn important skills. Such embedding ensures that intervention is delivered in ways that are acceptable and supported by families and encourages generalization and functionality (Woods & Kashinath, 2007). The practice of bringing materials into a home when working on developmental outcomes, otherwise known as the “toy bag approach,” is contradictory to the philosophy of natural environments (Childress, 2004; McWilliam, 2010). The argument against toy bags is grounded in the belief that learning occurs between visits (McWilliam, 2000). Bringing special materials that are available for only 30 to 60 minutes of a child’s week does not provide necessary opportunities for practice and learning. Walking into a home without materials was similar to walking into a formal dinner party without wearing a tie or jacket; it just did not feel right. Initially, we argued that without the proper equipment it would be impossible to do our jobs. Our toys, books, and puzzles made us feel comfortable, much the same way a special blanket makes a young child comfortable when visiting new people or places. Yet, as we spent more time working in families’ homes, we found ourselves feeling much more confident and capable, and noticed a decreased need for our “toy bag.” We began to teach...
parents how to use and adapt materials in their home. It makes sense that a child pulls himself to stand using the couch or practices stair climbing on the steps that lead to the family room. A child can stack plastic containers rather than 1-in cubes. When families realize they have what they need in their homes and learn how to use these materials as part of their own routines, the real magic happens.

In the event that we may need to assess a child’s interest or engagement with certain types of toys, we may bring materials with us and leave them with the families to try. We have established a lending closet so that equipment can be left with families, often on a trial basis, to support unique needs. We put together tool kits, supported through private funds, to provide families with useful aids in daily routines for feeding, communication, and/or sensory difficulties. Although these materials can be helpful and stimulate ideas, we are very careful not to become overreliant. We have found we are better able to follow families’ lead when we arrive without our special materials. For example, if an interventionist brings a puzzle to a visit, she will work with that puzzle. Upon reflection, we wonder if doing so leads to a missed opportunity to address a more pressing need.

**LESSON 3: PARENTS ARE THE KEY**

Families are key decision makers in early intervention. The Individualized Family Service Plan (IFSP) describes a family’s needs, priorities, and resources as well as anticipated outcomes for the child and family. Services and supports focus on strengthening family functioning. To this end, intervention strategies need to be carefully and individually chosen to match the parents’ priorities (McWilliam, 2001; Woods et al., 2004). It is crucial to focus on children’s strengths and ability to participate in family activities, as well as to acknowledge families as decision makers not only in the IFSP development process but in every aspect of early intervention (ERIC/OSEP Special Projects, 2001; McWilliam, 2001). In fact, current research shows that parents can be effective interventionists when supported by professionals (Symon, 2005; Woods et al., 2004; Woods & Kashinath, 2007).

To create and sustain a trusting relationship, we are sure to address parent concerns at each visit. We ask how everything is going, what is new, what new concerns have arisen and bow we can help. As families share thoughts and feelings, we focus on being warm, responsive, and helpful. Families that are receiving early intervention services are often faced with many concerns that supersede the developmental issues of their child. Therefore, family needs and concerns drive the visit, along with the developmental needs of the child. These 2 areas are so interrelated that it is difficult to separate them.

We believe that trust and respect are essential in developing a good working relationship between primary service providers and parents. Both parties need to understand that they are working together to reach a common goal, which is to help the child reach his or her potential. We need to be able to discuss difficult subject matter, share opinions, problem solve, brainstorm, and communicate. Families learn to rely on their PSP for an unbiased opinion, and the PSP learns to respect parents’ wishes, even if different from her own.

As we embraced this idea of mutual trust and respect, we quickly discovered that our primary job is to empower parents. It was our role to develop their strengths, skills, and confidence to move their children toward family-generated outcomes. We were not the experts. We became facilitators. We noticed parents becoming confident in recognizing and developing their children’s skills. We saw parents looking at their children with different “eyes” as they identified and tried new strategies to support outcomes. Families shared stories of being active participants in their children’s intervention. They recalled adjustments, modifications, and new skills that had emerged between visits. This new partnership with families presented positive
outcomes on many levels. One family struggled to provide adequate nutrition to their son with severe feeding issues. The PSP worked closely with the family around daily routines that involved eating. Over time, the issues were resolved and the child was able to grow and thrive. The parents were finally able to satisfy a basic need of their child, putting to rest their feelings of inadequacy. Not only was their young son able to eat and grow; but the family was able to establish mealtimes that were social, interactive, and included all members of the family.

**LESSON 4: RESPECT FAMILY NORMS AND VALUES**

Early interventionists must respect family’s cultural norms, diverse backgrounds, and differing communication and learning styles (National Association of School Psychologists, 2003; Woods & McCormick, 2002). Providers need to not only be aware of their own cultural biases, but refrain from drawing conclusions or passing judgment on the basis of those biases (ERIC/OSEP Special Projects, 2001). On the other hand, interventionists need to be aware that families may be viewing us with their own biases and their own cultural views of disabilities (National Association of School Psychologists, 2003). It takes time and effort for families to learn to know and trust us.

*Learning to overcome our own cultural biases has proven, at times, to be challenging. We have learned that it is important to reflect upon those things that are unfamiliar or uncomfortable to better understand. For example, one team member remembers the following event. As I waited at the door, I watched a young father dance with his son while they vacuumed the living room. I saw him tenderly support his son, making sure he was able to feel safe, yet challenging his balance. He continued to dance while encouraging his son to sing along with him. As I watched the scene, I wondered how I would have viewed this man in a different context. The multiple tattoos and shaved head may have caused me to assume things that were not true at all. Now, I see a loving father capable of providing necessary intervention during the family’s daily routines. I feel privileged to share this part of their family life.*

**LESSON 5: LEAVE YOUR “TITLE” AT THE DOOR**

Transdisciplinary teaming requires that professionals cross disciplinary boundaries to address the various developmental needs of children, as well as the families’ needs for support. In order for a transdisciplinary approach to be effective, professionals must engage in role release and role acceptance (Bruder, 2010; Sandall et al., 2005). In other words, professionals need to be willing to support and teach each other, as well as learn from each other, so that individual team members have the competencies and skills necessary to address a variety of needs. Transdisciplinary teaming is recommended by various professional organizations (eg, American Speech and Hearing Association, American Occupational Therapy Association [AOTA], and American Physical Therapy Association). In fact, AOTA uses the terms “mentoring,” “coaching,” and “collaborating” when describing skills necessary for serving infants and toddlers in natural environments. The AOTA further asserts “the very nature of that which occupational therapy addresses . . . can be identified by the occupational therapy practitioner and implemented on a daily basis by the family or others” (American Occupational Therapy Association, 2010, p. 1).

*Going from an early intervention teacher to an early interventionist may not sound like much of a change. But when that means taking a teacher out of a classroom surrounded by a team of experts, and dropping her into a home all alone with a parent and child with special needs, she might as well been asked to teach 10th-grade biology. The mere thought of an entire hour alone—in someone’s home—without “crutches” of expertise was absolutely terrifying. One team member recalls feeling as though she bad*
exhausted everything she knew in that first hour the first day making her question if she could effectively support this family, answer their questions, and provide strategies in the weeks yet to come.

Our knowledge and skills are constantly tested in this transdisciplinary model. Yet, rather than causing feelings of incompetence as we initially experienced, we are starting to feel empowered by our ability to teach and learn. We have recognized that no professional could know “enough” all the time. We have learned to ask for help when we need it and to seek the input of others as a vital component of support and decision making. We have become “teachers” to our peers so that each of us is well equipped to support every child and family on our caseload. We now know that sharing the knowledge and skills we have among us is as essential to the process as anything we could do when working directly with a child.

Admittedly, each of us is at different levels of comfort functioning as early interventionists. Some of us struggled with role release . . . “Can a physical therapist really support communication?” Others find role acceptance to be more challenging . . . “I have no idea what to tell this family about feeding. I wasn’t trained in that!” We may always have these struggles and challenges, but we celebrate our progress. We no longer view ourselves solely through the eyes of the specialists we were trained to be. We usually don’t even describe ourselves by our educational backgrounds and disciplines anymore. These efforts were validated at a recent home visit when a grandmother reported, “The speech therapist at the hospital asked which therapist comes to see Sam on Thursdays, and I said, ‘Honestly I don’t know. She seems to know what his needs are and we work on everything’.”

It has been a powerful transformation for us as we focus on a more holistic approach to serving children and their families. Children cannot be broken into parts, development cannot be looked at in isolation, and children’s needs cannot be separated from family concerns and priorities. We recognize that more than one developmental domain is involved in any daily routine. In addition, families’ priorities and concerns often center around the same routines. Mealtime is one example. A child uses communication skills to choose milk or juice. He uses fine motor skills to pick up food and bring it to his mouth. The ability to climb into a booster seat for meals requires gross motor skills like balance, strength, and motor planning. An assessment of the family may very likely show dinnertime as a concern. All of these things are interconnected for the child to eat dinner with his family, which means it has to be interconnected for us, as well.

LESSON 6: TAKE TIME TO REFLECT

Reflective practice in early intervention is characterized by taking the time to step back from daily events, documenting reactions to those events, and brainstorming with others to analyze and problem solve issues and experiences (Gatti, Watson, & Siegel, 2011; Wesley & Buysse, 2001). Engaging in reflection with others allows interventionists to better support families, in turn allowing parents to better support their children (Gatti et al., 2011). The primary service provider and the family work together by reflecting upon the effectiveness of the intervention, activities, and progress to ensure continuous improvement.

Reflection has increased awareness about how we work, and the impact of our work, leading to rich opportunities for professional growth and development. After working with a child who has particularly challenging needs, I often reflect in the car. I wonder, “How effective was I?” “Did I talk too much about issues the parents may not be concerned about?” “Did I really hear what the parents need?” Once I sort through my own thoughts and worries, I share them with my team. When I interpret my behaviors through the lens of the team, it helps me grow as a professional. I leave with new perspectives to guide my practice for future
visits, knowing that on my drive home again, there will be another opportunity to reflect.

We also guide families to reflect by making careful observations, asking questions, and providing feedback. Through reflection, family members are able to determine strategies, implement ideas, and measure effectiveness. We have noticed parents are able to support their children with greater confidence as a result of this guided reflection, and that many are reflecting without any guidance from us. A mother shared the first time her son signed “more” without a prompt. I asked her what was different this time. She said she noticed that if she waited a little longer, he would use a sign without any prompting from her. She wondered what would happen if she practiced waiting and noticed that he is signing even more. Imagine how empowered parents feel when they step back, wonder, and see results like this all on their own.

As we work with parents to reflect upon their experiences, our role often shifts from that of coach to that of learner. For example, one parent used an inflatable ring that a baby sits in to work on walking in the backyard pool. I had never thought of that. It is humbling to know that I have 30 years of experience, but a mother with no formal training can come up with a strategy that not only works for her child, but that I can share with other families with similar needs.

IMPLICATIONS

Looking back, we realize we went off into the great unknown as prepared as we could have been. Reflecting on ideas and techniques we had seen our colleagues use effectively, brushing up on promising practices, and browsing books on home visiting were helpful tools to get us started. As we transitioned to doing our work differently, we scheduled joint home visits with each other to learn even more techniques to carry over with families. We gave up feeling like we had to be the expert in all areas of child development. Saying “let me check with my team about that” and get back to you” has become accepted practice.

For some of us, this radical change felt comfortable more quickly. For others, it took much longer. We had to respect where each one of us was in the process, while holding on to where we hoped to be. Now that we all embrace this new way of doing our work, we realize that change, while difficult, can become easier and more relaxed when we support each other and work toward a common vision. Our focus has shifted from emphasizing what we are best at providing to providing what is best for each family and each child.

A key discovery in our journey was the need for professional development focusing on the processes and skills necessary to function as a transdisciplinary team. Shifting to this different model required mentorship and coaching, which we received from administrators, technical assistance providers, and each other. Training, technical assistance, and meaningful, ongoing professional development are crucial to the success of any change (Sandall et al., 2005). The support our team received from each other was probably the most important aspect for our day-to-day functioning. However, we also needed support from our district administration, our school board, our local education association, and our colleagues. The move to this new model also required unparalleled support from our special education director, who was willing to guide and support us on this journey. We also were fortunate to receive technical assistance support from our Intermediate School District, the educational service agency in Michigan. This technical assistance consisted of ongoing coaching, guidance, and mentoring from consultants. The consultants acted like a “help-desk,” providing emotional and practical support. Specially, they helped us to remain grounded in our guiding philosophical principles. They helped us understand rules, regulations, and funding implications. They provided us with evidence-based literature and materials. Finally, they provided a neutral perspective allowing us to creatively brainstorm solutions to barriers that inevitably arose.
Although we were provided with professional development and technical assistance to help us shift our practice, our preservice programs did not prepare us to work in this transdisciplinary fashion. Our experience mirrors that of many early intervention service providers. In fact, it is not uncommon for early intervention service providers to enter the workforce inadequately prepared to work with families as they are mandated to do (Chang, Early, & Winton, 2005; Winton & McCollum, 2008). In fact, less than half of the state early intervention systems have service providers who trained to deliver services for infants, toddlers, and their families (Center to Inform Personnel Preparation Policy and Practice in Early Intervention and Preschool Education, 2004; Bruder, Mogro-Wilson, Stayton, & Dietrich, 2009).

In addition, in a survey of 2- and 4-year preservice training programs for early childhood professionals, researchers found great variations in content, specifically in the limited emphasis on family-professional collaboration (Chang et al., 2005). Early intervention training should include child development-related competencies as well as adult learning competencies to be able to work successfully with the adults who care for the child in the child’s natural environment (as opposed to the medical model of delivering services at clinics or specialized and segregated settings). In a national survey of state Part C personnel information, “many of the respondents expressed concern that the [personnel preparation] programs in their state rarely addressed the needs of infants and toddlers, or taught about family-centered ways to deliver services in natural environments” (Center to Inform Personnel Preparation Policy and Practice in Early Intervention and Early Childhood Special Education, 2004, p. 17). With the legal mandate for family-centered services in natural environments, the lack of high-quality training in early intervention becomes a critical issue.

In spite of our initial professional preparation, we were able to successfully transition to this new model. Our team had many assets to draw upon; we have numerous years of experience working with young children, a commitment to provide the best intervention to young children and families, as well as a supportive network of mentors. Yet, not all early intervention teams have access to the same supports. Therefore, we feel strongly that the time has come for professional preparation programs to teach professionals the knowledge and skills necessary to effectively deliver services in natural environments. We have seen the difference. Anecdotally, we know that children are meeting and exceeding their IFSP outcomes more rapidly than ever before, children are receiving less outside therapies, and families are using strategies as part of daily routines. Recently, we surveyed parents to obtain feedback about their experiences with our program. Although we have received many positive comments, the following quote eloquently reflects the perception of the families we serve.

The past two years have been very difficult for our family from the difficult pregnancy, to the early delivery, to the realization that my son has a serious disability. It is easy to feel like you are simply a diagnosis in the medical bureaucracy. However, this program helped me feel like I had a personal coach to help me keep my spirits up, navigate the medical jargon, and keep doing things to help my son’s development rather than just giving up. It has helped me to stay aware of his strengths while working to improve his weaknesses.

The following vignette revisits the example given earlier.

Now that Bella’s early intervention services are delivered in her home, the early interventionist has supported the family with tips for feeding and increasing Bella’s calories. One strategy suggested by the interventionist was to use rolled up towels to help her sit steadier in her highchair. Bella is now able to use her hands to bring a cup to her mouth. Bella’s play includes pretending to feed everyone, her cat, her dolls, and especially mom! The family no longer feels as though they have to make a choice between receiving early intervention and risking exposure, since the intervention takes place at home.
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REFERENCES


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