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2 Collaboration and Teamwork with Families and Professionals

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This chapter discusses issues related to the creation of collaborative relationships with families, team members, and other professionals, including the following:

- The importance of family–professional collaboration
- The family-centered approach and family systems theory
- The early intervention team
- Team models in early intervention
- Strategies for effective collaboration and communication
- Best practice highlights

Case Study: Mason

Mason is a 5-month-old child who was born 8 weeks early because his mother was in a car accident. Because of complications associated with the accident and his premature birth, Mason has a brain injury and has been diagnosed with cerebral palsy and visual impairment. He is the fourth child in his family. Mason was referred to a local early intervention program by his pediatrician shortly after being discharged from the hospital at 3 months old. Following the evaluation and assessment of his development, Mason was found to be eligible for early intervention services, and an individualized family service plan (IFSP) was developed. Mason's parents and child care provider were present during the initial IFSP meeting, where outcomes were written and service recommendations were discussed.

The team had to sort through several differing recommendations before reaching consensus. Some team members recommended that Mason receive services from a primary service provider, who could help the family with integrating strategies from all disciplines into Mason's daily life. Another team member strongly felt that Mason should receive multiple services, such as special instruction, physical therapy, and speech therapy weekly due to his significant disabilities. To reach a consensus, the service coordinator facilitated

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an open discussion that allowed all team members, including Mason's parents, to express their positions. Finally, the team determined that Mason would receive services from a physical therapist, who would be his primary service provider, as well as special instruction services from an educator as a consulting service, to help his family and child care provider encourage his development in a variety of settings throughout the day. The parents stated that they felt comfortable with this approach, knowing that further consultations with the speech-language pathologist may be added to the IFSP at a later date as Mason began to communicate more purposefully. In fact, when Mason was 2.5 years old, his primary provider changed to the educator as his intervention outcomes began to focus on more learning and communication issues in preparation for transition to preschool. Mason received early intervention services until his third birthday.

Because Part C of the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 (PL 108-446) requires family members to be involved in all aspects of their child's services—to the extent that they choose—caregivers are clearly essential players in the implementation of early intervention. Mason's parents were involved in the early intervention process from the beginning and actively contributed their insights and opinions about Mason's strengths and needs during the evaluation and assessment, as well as throughout the development of his IFSP. They participated in the discussion about services as equal team members with the professionals at the IFSP meeting. Mason's parents' participation was critical to ensuring that the services on the IFSP met their family's needs and the needs of their son.

There has been a paradigm shift in early intervention from viewing the child with special needs as the key recipient of services to viewing the *child's parents, caregivers, and family* as the principal recipients of services and supports. The process of family–professional collaboration enhances parents' natural abilities to influence their child's development and learning. Parents have been found to be good advocates for their children when they are provided with information, encouragement, and optimism (Trivette & Dunst, 2004). Through meaningful family–professional relationships, parents receive experiences that will hopefully lead to positive outcomes for themselves, their child, and their family.

IMPORTANCE OF FAMILY–PROFESSIONAL COLLABORATION

A child's family spends the most time with a child and is the real constant in a child's life. Involving parents and other family members in the intervention process is more powerful than focusing exclusively on the child. If Mason's team had determined services from the perspective of what *he alone* would receive during intervention visits, then prescribing multiple services might have made sense. Instead, they considered what supports his *family* would need to support Mason's development and together, with his parents, determined that fewer direct services were more appropriate. This is because team members would be consulting across their disciplines and providing integrated intervention alongside his family; consequently, Mason would ultimately receive more intervention during and between visits. When families are involved, trained, and supported, children are given the opportunity to receive interventions when professionals are not present because their parents or caregivers feel prepared to provide the intervention. Encouraging family members to choose their level of involvement in intervention, program planning, decision making, and service delivery benefits both the child and the family (Sandall, Hemmeter, Smith, & McLean, 2005), and it also permits service providers to be more effective.

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Interventionists must prepare parents or caregivers to understand how and why interventions can be used in their daily lives because parents are the ones who will be interacting with the child long after professionals leave. Formal early intervention accounts for less than 20% of an infant's or toddler's awake time (Bruder, 2001). For this reason, service providers need to develop outstanding communication skills to interact successfully with the range of adult personalities and styles they will encounter in families in order to reach the child (Turnbull et al., 2007). Basic effective interpersonal skills, such as building trust by following through on plans, actively showing attention during conversations, and pausing (Cheatham & Ostrosky, 2009), are courtesies viewed as critical to successful collaboration from a parent's point of view. Because positive parent–professional collaboration is essential for meaningful services and outcomes, attempts are now being made to develop training and assessment instruments that evaluate the use of parent–professional collaboration in the field with families (Basu, Salisbury, & Thorkildsen, 2010).

The reality is that the field of early intervention is a relationship-based discipline. Without a sound relationship with the child, the child's family and extended family, and other important people in the family's life, it is impossible to make meaningful changes in a child's development. To achieve this, service providers must develop respectful, nonjudgmental reactions to families' values, beliefs, and lifestyles (Zhang & Bennett, 2001). This will lead to strong, lasting relationships with families that are undeniably strengthened by the amount of time that families and interventionists share. The parent–professional relationship should not be confused with a friendship. Although collaborations with families are cordial and supportive, there is a necessary professional boundary established, which is not present in friendships.

Time is a fundamental resource for any family (Brotherson & Goldstein, 1992). When time is not available, it can cause major stresses in a family's life. In the process of parent–professional collaboration, it is critical that service providers understand the importance of using their time with families efficiently and recognize time as a resource that is limited for many families. Time is always a key factor in the involvement level of a family with the early intervention team.

Parents and caregivers are viewed as fully participating team members on the early intervention team. They are given the opportunity to be the primary decision makers regarding planning services, identifying the locations for the delivery of services (e.g., the child care provider's home), identifying outcomes, and determining whether collaborative recommendations have benefited the child and family. Parents also provide necessary information for evaluations and assessments. Although all decisions are team decisions, the family members have the final word on the services the child receives, and their commitment to the process is critical to the success of their child's intervention. Since the family is the primary change agent in the child's life and directly influences the child's development, family members are invited to participate in all aspects of the child's intervention. In addition, families should be encouraged to do so in a way that best suits them. Some families, such as Mason's family, elect to be directly involved in every aspect of their child's services, while others may choose to participate in a less active way. Each choice is followed because it represents the preference of that family. When families are encouraged to be active members of the team, parents tend to participate more, their children tend to have positive long-term developmental outcomes, and parents report an increase in their sense of *empowerment*—the belief that they can make a difference in another person's life (Trivette & Dunst, 2004). Supportive parent–professional collaboration is one of the key principles of family-centered intervention (Wolery & Hemmeter, 2011).

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THE PROCESS OF THE FAMILY-CENTERED APPROACH

The family-centered approach to early intervention is a way of thinking that leads to a set of practices in which families or parents are considered as the most important decision makers in a child's life (Sandall et al., 2005). It involves a process that acknowledges that early intervention programs and professionals must respect the unique values and priorities of families, encourage families' strengths, and support parents' sense of competence in order to foster a child's progress (Dunst, 2001; Keilty, 2010). During every interaction, professionals should express their belief in the capability of parents to support their own children. Trivette and Dunst (2004) found that a staff's strong beliefs about parents' abilities to support their child's learning were linked to more positive parental judgments about their parenting competence. In other words, when professionals provide family-specific coaching and support, family members are better equipped to support their child's development.

The family-centered approach is based on the belief that most parents of children with special needs possess the emotional investment necessary to encourage and motivate their child's development, particularly when given appropriate and individualized supports from professionals (Trivette & Dunst, 2004). Families who are not able to focus on the child's needs may have issues that are more pressing, such as when a family is facing homelessness or when a parent has substance abuse or mental health challenges. Other families may not feel that intervention is necessary, so they may be reluctant to participate, such as when a family is mandated to receive early intervention by the court system or when the family does not recognize the child's special needs. In any of these cases, the family-centered approach is individualized to meet families where they are, meaning that time is taken to build rapport with family members and ensure that supports revolve around their priorities and strengths. This approach acknowledges that children and their families possess strengths that are just as important as their needs.

These beliefs lead to offering families *positive helpgiving,* which is a style of offering assistance to children or families with the intent that the help will have positive consequences for those receiving it (Sandall et al., 2005). One way of achieving this is using family priorities for establishing outcomes and using multiple techniques to engage family members in discussions about how to develop their child's needed skills during the process of daily living. This kind of capacity-building, positive helpgiving (Dunst, Trivette, & Hamby, 2007) builds on the strengths the child and family displayed during the initial assessment and uses new strengths as they emerge. This approach is exemplified by Mason's case. Because Mason's older sisters were clearly very attached to him, the strategies for implementing some of his outcomes on the IFSP involved his sisters interacting with Mason while their mother prepared dinner, which was a particularly busy time of day for the family. Research has shown that meeting family-selected outcomes during family routines can improve parents' reported perceptions of their family's quality of life (Epley, Summers, & Turnbull, 2011). Once again, professionals are reminded that they are not working with the child but rather with the entire family, which can lead to positive changes for both.

When implementing this approach, professionals should ask parents what amount and type of involvement and services are best suited for their child and family, then attempt to provide services that match these priorities. This information is generally gathered through the process of collaborative consultation. Service providers should also use *coaching*—a collection of strategies such as listening, prompting, joint problem-solving, and planning—to promote changes in a child's outcomes by strengthening parent–child interactions and expanding parents' abilities to foster their children's learning throughout

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the day (McCollum, Gooler, Appl, & Yates, 2001; Rush & Shelden, 2011). Coaching is described in detail in Chapter 4.

Two common strategies are used in a family-centered approach. First, supports are provided to families in their selected natural environments. Within these settings, service providers and caregivers brainstorm ways to embed goals for the child into natural learning opportunities within families' daily routines (Raver, 2005, 2009). When working with infants and toddlers, professionals do not remove a family from its regular environment; rather, they work in conjunction with a family to make established routines more responsive to the child's current needs. For example, when Mason was approximately 2 years old, a priority for his family was for him to sit in the shopping cart at the grocery store for the entire trip. This was a very functional priority that directly related to Mason's motor skills and his ability to participate and learn during a regular family routine. Rather than only provide his family with exercises they could use at home to strengthen Mason's muscles, the educator and the physical therapist accompanied Mason's family on a trip to the grocery store to problem-solve with his mother about strategies to help Mason sit with appropriate support in the cart. Taking intervention out into the specific natural setting where it is needed makes intervention more meaningful for the family and is aligned with family-centered practices.

A second common strategy is attempting to support parents in their efforts to manage their own and their family's stress. Families of children with disabilities appear to be susceptible to increased stress. They report feeling isolated and may have smaller support networks than families of children without disabilities (Raver, Michalek, & Gillespie, 2011). All parents have to cope with family stress. However, parents of children with special needs tend to have additional daily stressors that may impede their child's development or negatively affect how the family functions (Hooste & Maes, 2003). Again, consider Mason's family. During the first year of intervention visits, Mason's mother frequently talked about the strain of making the many doctors' appointments required for him, as well as the difficulty of finding a child care provider who was comfortable managing Mason's needs. Mason's mother stated later that just being able to discuss these concerns with the interventionist seemed to ease the stress of these realities.

Even the best-intentioned early intervention programs may inadvertently introduce stress into a family's life. Therefore, service providers must take special care in the way they manage services to ensure that unintended stress is not introduced. To monitor this with Mason's family, the service coordinator regularly checked in with family members about how they were feeling about their services and if changes were needed. Services were coordinated so that providers consulted one another and avoided conflicting recommendations, which could be frustrating for the family. When requested, providers also conducted co-treatments, visiting the home at the same time when the family's schedule was busy, to reduce the number of visits to the home. The service coordinator coached the family in requesting that doctors' appointments in the same hospital be scheduled either on the same day or across several weeks to reduce the amount of appointments in any one week. The service coordinator and Mason's mother also discussed child care options among family members and friends who might be able to assist with child care, ultimately identifying a friend at the family's church who was comfortable caring for Mason.

FAMILY SYSTEMS THEORY

Family systems theory is the foundation for the most integral guiding philosophy of early intervention. A family is an interconnected system, with the activities of each member affecting all other members as well as the family unit as a whole (Turnbull, Turnbull, Erwin,

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Soodak, & Shogren, 2010). In other words, what benefits or stresses the child is also likely to benefit or stress the family as a whole because of the connections among family members. For example, when Mason was having significant sleep disturbances, his parents were sleep deprived, which affected their interactions with one another and with Mason and his sisters. Once Mason's sleep was regulated, all members of the family eventually experienced relief; they were able to feel more like "themselves" and manage the needs of the family better.

Family systems theory describes three major characteristics that influence how a family manages family life: 1) family characteristics, 2) family interaction, and 3) family functioning. Family characteristics are attributes that a family shares as a unit, such as a family's size, cultural background, socioeconomic status, and the characteristics of individual members. Each of these may influence a family's adaptation to receiving early intervention services and the family's response to a child having special needs. This is illustrated by one of Mason's mother's comments during the first months of services: "With all of Mason's health problems and my own recovery from his birth, I have been thinking about leaving my job. It will be tight. I think we can make it but it won't be easy—and Mason isn't an easy baby, either." Obviously, the severity of a child's disability, temperament, and behavior can influence a family's adjustment and functioning.

Family interaction involves the relationships between individual members of a family (Turnbull et al., 2007). When there are changes within a family, as with the birth of a child with a disability or the identification of a developmental delay, dramatic changes may occur in the roles of individuals within a family. Mason's father's remarks show how relationships within families can change, resulting in either positive or negative consequences for individual members that also may have an influence on the family as a unit: "At first I was obsessed about Mason's future. Would he be able to support himself or ever live alone? But my mother loved him from the beginning. He was just her little grandson—her first grandson.... She didn't see any differences. Honestly, that has helped me."

Family functions involve the needs that families are responsible for, such as economic support, daily care, recreation, socialization, and affection (Turnbull et al., 2010). Mason's mother made this observation about the family's daily lives: "With three other kids, sometimes it is hard to find the time that Mason needs.... I worry that the other kids are getting the short end of the stick." It was suggested that the other children help with Mason's learning activities while the family members went through their usual routines; in this way, the older children, as well as Mason and his mother, could benefit. Every family is unique and manages challenges differently. Parents, siblings, and extended family members frequently respond to delays in a child's development or the identification of a disability in different ways as well.

Parents' Reactions to Delayed Development or a Disability

Parents often do not perceive a disability in the same way as professionals. Mothers have described feelings of denial and wishful thinking, followed by searching for information, seeking social support, and *reframing* (i.e., restating a situation in a more hopeful way) to cope with their children's initial diagnoses (Bingham, Correa, & Huber, 2012). Within the same family, mothers and fathers usually experience different emotions. The sequence of reactions and the time needed for adjustment are different for each parent—and each family. Service providers must remind themselves of this fact often. However, the diagnosis of a disability or delayed development may not alter established routines of caregiving. For instance, research has found that there is no difference in the level of involvement between fathers of very young children with disabilities and fathers of children without disabilities

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(Dyer, McBride, Santos, & Jeans, 2009). Although there was no evidence that fathers of children with developmental delays were less involved with their children, the results did not show that responding to a diagnosis of a disability resulted in fathers becoming more involved. Despite the fact that mothers of children with special needs are likely to have increased child care responsibilities, there is also no evidence that fathers tend to increase their engagement with their children to relieve maternal burdens (Dyer et al., 2009). This information should be useful to service providers who often find that mothers report feeling overwhelmed and lacking in daily family support. Developing a personalized approach to each child and each family is the best way to support families with varying resources and needs (Bailey et al., 2006).

Siblings' Reactions to Delayed Development or a Disability

Parents' attitudes about a disability or developmental delay are critical in shaping siblings' adjustment. When parents take a positive view, siblings tend to follow their lead. However, in some families, siblings' needs may be neglected due to disproportionate parental time being devoted to the child with special needs, which may encourage siblings' negative feelings. For this reason, service providers must help support parents in creating a balanced family life. A balanced family is one in which the needs of all family members are appropriately and equally addressed across time. To support families in maintaining this balance, service providers should be flexible when scheduling visits to accommodate changing family needs, try to include siblings and other family members during visits, and help families develop strategies that encourage interaction between siblings and inclusion of the child with disabilities in activities that the whole family enjoys.

Encouraging open communication regarding both positive and negative feelings can also aide sibling adjustment. Siblings need accurate information about a disability to allay fears that may stem from misunderstandings. It is beneficial for professionals to promote strong sibling relationships in families. During the family's visits with the service provider, Mason's older siblings were invited to join intervention activities and ask questions. By participating during the visit, Mason's siblings learned simple activities that they could do with him, such as holding a rattle in his hand and helping him shake it. The oldest siblings enjoyed having special intervention "jobs," such as playing with Mason with his lighted toys each day or helping him learn what simple words meant, such as asking him, "Want to be picked up?" then touching his sides before getting him out of his crib after naptime. They enjoyed having important roles to play in Mason's intervention and felt proud when they "taught" him something. Activities such as these help siblings develop strong bonds. Children with disabilities or developmental delays tend to develop better social skills, and families seem to report less stress.

Most families eventually make successful adjustments to their situations and report positive effects, such as increased family cohesion and a renewed appreciation for life (Raver et al., 2011). Over time, most parents and extended family members rebuild their hopes and learn to adapt to the new circumstances of their lives (Gallagher, Fialka, Rhodes, & Arceneaux, 2003). The reactions and behaviors of caregivers, siblings, and extended family members are important to service providers because they work with the entire family, not merely the child.

Early intervention views child, parent, and family functioning as complex processes (Bruder, 2010). Early learning and development are influenced by interactions between environments experienced by a child, as well as the characteristics of the child and the adults around that child. Family systems theory is a way of conceptualizing how the char-

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acteristics of families, and those important to them, affect their response to critical events. Understanding this theory permits service providers on the early intervention team to more effectively support very young children and their families during a vulnerable time in families' lives (Davis & Gavidia-Payne, 2009).

EARLY INTERVENTION TEAM

From its inception, early intervention has involved many disciplines and fields of study, such as psychology, health, early childhood education, special education, physical therapy, occupational therapy, and speech-language pathology—all working together to support a child and the child's family (Bruder, 2010). The actual combination of professionals who make up the early intervention team depends on the child's IFSP. Regardless of team composition, the primary task of this team is to support the family's competence and confidence with promoting a child's development toward the outcomes desired by the family in the child's everyday life.

By definition, a *team* is a small group of people with complementary skills, common purposes, goals, and approaches for which they hold themselves jointly accountable (Katzenbach & Smith, 1993). These characteristics of a team are key to successful early intervention and to ensuring collaborative and nonduplicative services and supports. Two main types of teams provide supports to families during the early intervention process: evaluation and assessment teams and IFSP teams.

Evaluation and Assessment Team

The evaluation and assessment team is typically composed of a small group of two or three professionals and family members who meet to gather information about a child's development. This information is collected by formal developmental assessments, observation, parents' reports, and review of the child's medical and developmental history. The evaluation and assessment team uses this information to determine a child's eligibility for IDEA Part C services, identify the child's functional strengths and needs, collaboratively identify with the family ideas for interventions, and gather information needed to develop the IFSP for children found to be eligible for services. The evaluation and assessment team may or may not be the same group of professionals who will also help the family develop the IFSP. The composition of both teams is usually determined by a family's stated priorities, a child's strengths and needs, and state and local policies and procedures.

Parents are important members of the evaluation and assessment team because they are the only team members who can report on the child's behaviors and abilities in everyday activities. Professional team members can facilitate active parental involvement on the team by preparing families for what questions they will be asked and what activities the child will be expected to do, as well as helping families prepare information they would like to share. Parents or caregivers generally become more active contributors in the assessment and planning process when they feel comfortable and prepared (Byington & Whitby, 2011).

Individualized Family Service Plan Team

The task of the IFSP team focuses on the development of the IFSP, which involves collaborating with parents to determine appropriate outcomes for the child's development based on assessment information and the family's stated priorities. The IFSP team determines which supports (e.g., assisting the parents in finding reliable child care) and services (e.g., vision services for a child with a visual impairment) are necessary to help the child and

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family achieve their goals. A team representative, known as the *primary service provider,* works directly with the child and family or caregivers during visits to develop individualized intervention strategies to address IFSP outcomes. Support is provided to help families understand their important role in enhancing the child's development and to feel confident implementing learning activities during their daily lives. The primary service provider also collaborates with all team members to provide individualized support to the family. IFSP team members conduct ongoing assessments and link the family to needed resources such as housing assistance, evaluation for equipment (e.g., gait trainer, wheelchair), or counseling, when appropriate. As the child approaches his or her third birthday, the IFSP team begins a formal transition process and develops a plan for easing the shift from early intervention to preschool special education, which is provided under Part B of IDEA (2004, § 619), or another community service option.

The roles of IFSP team members often change over the course of the child's participation in early intervention. Who participates on the IFSP team and what role each professional plays is individualized to the child and family outcomes, priorities, and resources and the team's decision-making process.

Professional Team Members' Roles

The most important member of the early intervention team is the parent or caregiver. Another very important member is the professional who is identified as a family's primary service provider. Service providers from any discipline can be designated as the primary service provider, depending on who is most appropriate to help the family and child. This designation may change over the time that services are offered as a child's and family's needs change. The process for determining services and service providers is discussed further in Chapter 3.

Although the same team members worked with Mason and his family throughout their early intervention experience, the primary service provider changed when Mason was approaching his third birthday to meet his changing needs. It is the primary service provider's responsibility to support the child and family by integrating information from consulting team members and helping the family address the child's development in all areas of need. The roles of educators, therapists, service coordinators, medical personnel, and other specialists are described in the following sections.

Educator The educator usually has training in early childhood education, early childhood special education, or child development. This provider helps the team gain a global, whole-child perspective of a child's development. The educator participates in screenings, evaluations, and assessments; assists in developing IFSPs; and provides special instruction if he or she is selected as the primary service provider. *Special instruction* is the phrase used in Part C of IDEA to describe educational services provided to infants and toddlers and their families. Educators may also facilitate playgroups or other group activities with children, siblings, and families. If group activities are arranged, they are often funded with money from outside of Part C funding. This service is discussed further in Chapters 3 and 4.

Therapists Speech-language pathologists and physical or occupational therapists also serve on early intervention teams. The roles are discussed further in Chapter 10.

Speech-Language Pathologist The speech-language pathologist has training in developing and improving communication and speech. Speech-language pathologists

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typically get little direct experience with infants and toddlers with special needs during their graduate training, although the field is embracing family-centered practices in natural environments (Woods, Wilcox, Friedman, & Murch, 2011). These specialists address communication development; participate in screenings, evaluations, and assessments; participate in IFSP development; and provide specific speech and/or language interventions in natural settings. Some speech-language pathologists also treat oral-motor and feeding issues.

Physical Therapist Physical therapists have been trained to facilitate, improve, and maintain motor development and functioning. They are involved in screenings, evaluations, assessments, and IFSP development; they also provide motor interventions in natural settings. Because infants and toddlers with developmental disabilities and/or delays often have difficulty generalizing and maintaining new skills, these children learn motor skills best through high-frequency, naturally occurring activities in their natural environments (Shelden & Rush, 2001). Providing motor-related services in natural settings decreases the problems related to poor generalization because the child has an opportunity to use and practice skills in the very environments in which he or she needs to use those skills.

Occupational Therapist Occupational therapists are trained to maximize fine motor development, play, feeding, and other adaptive skills. Like physical therapists and speech-language therapists, they may have minimal experience working with infants and toddlers in their training programs. Occupational therapists may also address sensory processing issues. They tend to participate in screenings, evaluations and assessments, and IFSP development and offer interventions in natural settings. As mentioned in Chapter 1, the emphasis in early intervention is to provide all supports to children with special needs and their families in their natural environments, rather than asking parents to take their children to clinics or an early intervention program office to receive therapy. Occupational therapists tend to use more family-centered approaches when they work in families' natural environments in early intervention than when they provide school-based services with older students, although strong differences occur among therapists and practice settings (Fingerhut et al., 2013).

When services are provided in natural settings, parents are immediately more involved in intervention visits; they learn by practicing intervention strategies with their child and by watching professionals use techniques that can later be used in the family's daily lives. Training parents to provide the intervention is a viable, time-saving, and evidence-based alternative to clinic-based services for all therapists (e.g., speech-language pathologists, physical therapists, occupational therapists). The time saved through the use of coaching the parent in skills and therapies the child needs makes it possible for more children to be served at a lower cost per child (Hanft & Pilkington, 2000). In addition, children seem to learn more because intervention or therapy is ongoing and not separate from life experiences. As Shelden and Rush (2001) stated, "Intervention is not tied to a specific person at a specific place at a specific time" (p. 4). The child actually receives more intervention when the parents and caregivers are able to use intervention strategies throughout the day—more than the child could receive if intervention focused on what could be accomplished by one person during one visit to the home each week.

Service Coordinator The service coordinator usually has training in a variety of child- and/or family-related disciplines. This person acts as a case manager who oversees the implementation of the IFSP; collaborates with families' other team members and community partners; and links families to resources such as health, social services, or respite

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care services. In some programs, team members may have blended roles, serving as both a service coordinator and an educator or therapist, or they may have a "dedicated role" and only provide service coordination. The primary duties of a service coordinator are participation in screenings, evaluations, and assessments (but not necessarily conducting testing); facilitating IFSP development; ensuring that the IFSP is implemented as agreed; and serving as the primary point of contact for families.

Medical Personnel Any medical professional who works with the child and family can participate on the early intervention team. This may be a pediatrician, primary care physician, or specialist, such as a geneticist, developmental pediatrician, neurologist, physiatrist, audiologist, or nutritionist. These professionals usually serve on the team in a consulting role to ensure that interventions support a child's development and learning without interfering with a child's health needs.

Other Professional Members Depending on a child's delays or disabilities, other professionals may need to be included on the team. These team members commonly include a vision specialist, a hearing specialist, an infant mental health/behavioral specialist, or the family's child care providers.

Other Family-Selected Members

In addition to these professionals, parents or caregivers can designate other individuals whom they consider important to their family to serve on the team, such as extended family members and family friends.

To some extent, the role that each team member plays on the early intervention team depends on the model of service delivery used in the specific program. The interactions among team members of different disciplines and between the family and professional team members contribute to the success of the team and are linked to the teaming model. Understanding how team members interact and which practices are recommended for early intervention teams is important as teams come together to support families.

TEAM MODELS IN EARLY INTERVENTION

The needs of infants and their families often extend beyond the expertise of a single discipline. Teaming permits professionals from different disciplines to work collaboratively to implement services that will support a very young child in reaching his or her potential. To improve the efficiency of the different individuals who provide early intervention services, services should be delivered through an integrated team approach (Bruder, 2010). Most early intervention programs use some variation of three team models—multidisciplinary, interdisciplinary, and transdisciplinary—to deliver services.

Multidisciplinary teams include professionals from different disciplines who typically work with limited opportunities for collaboration across disciplines. Team members may obtain consultations from different disciplines, but assessments are conducted individually by each team member. For example, the speech-language pathologist and the physical therapist may independently conduct the communication and motor-related assessments. Parents may meet with individual team members alone. This professional is responsible for implementing his or her "portion" of the IFSP. For example, the speech-language pathologist only addresses IFSP outcomes related to communication. Discipline-specific members of these teams recognize the importance of the contributions of other disciplines but may have only informal, infrequent communication with other team members. This approach

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lacks the benefits of team synthesis and, in some cases, may result in duplicative services for families.

Interdisciplinary teams involve professionals from different disciplines conducting their assessments separately but sharing this information with one another. Members may be willing to share development of the IFSP, but they tend to provide services that relate directly to "their part" of the IFSP. Periodic case-specific team meetings usually occur in an effort to manage problems by participating in group decision making.

Transdisciplinary teams make every effort to work together as an integrated team rather than as isolated discipline-specific professionals. This approach not only involves sharing the assessment process, outcome selection (in collaboration with the family), intervention strategies, and implementing services, but it also requires members to function as a cohesive unit by sharing knowledge and skills among the members (Raver, 2009). There is a strong sense of shared responsibility for all team activities and functions. The regular and systematic sharing of knowledge and skills across disciplines among diverse members of a team is called *role sharing*.

Transdisciplinary teaming uses role sharing to provide a child and family with the benefits of the whole team's expertise through collaboration between the primary service provider and other team members, who provide indirect support to the family through the primary service provider. Team members actively support each other in developing a good "working knowledge" of the other members' disciplines. Therefore, if they are selected to be the primary service provider and offer direct services to a child and family, all team members feel comfortable representing their colleagues (King et al., 2009). For example, consider Mason's transdisciplinary team. When the physical therapist was the primary service provider, she addressed all IFSP outcomes—not just those related to motor development—with the support of the educator, who acted in a consultative role. Later, the speech-language pathologist joined the physical therapist once a month during visits with the family to help integrate learning and communication strategies into home routines. As the primary service provider, the physical therapist represented the educator and speech-language pathologist by coaching the family to continue to use selected strategies throughout the month. Under the transdisciplinary model, no part of the IFSP is recognized as "belonging" to a particular discipline or provider; rather, the IFSP and all outcomes "belong" to the family.

The transdisciplinary team approach provides several benefits to families (Raver, 2009):

1. The approach involves fewer people working directly with the child and family.
2. It improves continuity and integration of information to the family, which can enhance embedding interventions into the family's routines and activities.
3. It increases consistency in services and information offered in the family's selected natural environments, saving the family time and increasing the variety of natural learning opportunities available to the child.

With infants and toddlers, transdisciplinary team members tend to conduct assessments together, often in the form of arena assessments (discussed in Chapter 3), share assessment results, and write integrated outcomes. The goal of transdisciplinary teaming is to provide services to children and families that might not be possible if strict discipline divisions were employed (Sandall et al., 2005). For example, a speech-language pathologist could teach all members of the team to use general techniques that foster early language development during an office team meeting before the designated primary care provider visits the family. One strategy commonly taught is the use of *parallel talk,* in which the objects and actions in a child's play environment are narrated (e.g.,

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"You are looking at a book," "That is a ball"; Raver et al., 2012). This parent-implemented intervention is the same strategy that the speech-language pathologist would have demonstrated and trained the parent to use if he or she had been the primary service provider (Kaiser & Roberts, 2011). This kind of knowledge and skill sharing does not mean that professionals give up their specific discipline-based skills, but that they use their discipline-specific training in a way that ultimately saves the family time and helps the family understand the interrelated nature of development. Regular contact and communication are important for any of the team models, but transdisciplinary teams cannot perform effectively without both.

Information and skill sharing is a characteristic commonly associated with transdisciplinary teaming, but it can also occur in interdisciplinary and multidisciplinary teams, although it rarely occurs as systematically. Often, a program will change the team model it uses to suit a particular program's purpose. Some programs use interdisciplinary teaming for evaluations and assessments, whereas they use transdisciplinary teaming for implementing services.

Frequent team meetings and consultations must be scheduled for team members to discuss assessments, outcome development, planning and strategy selection, evaluation of the IFSP, and family-specific issues, irrespective of the team model followed. The location, frequency, and method of team meetings and consultations depend on a variety of factors, such as program policies, team members' preferences (including the family), and the purpose of the activity. Team meetings might be scheduled to occur in the office, with or without the family present, or in the family's home or other natural environment. Consultations can occur by phone or e-mail, during shared visits, or in office meetings. When team members cannot be in a family's home, teaming strategies (e.g., videotaping a problematic or targeted routine) can help team members understand the context of a situation so that their feedback is more useful during team meetings. Even though teaming can be conducted in several ways, effective teams tend to be described as possessing a clear, common purpose and displaying sound communication.

DEVELOPING EFFECTIVE TEAMS

Effective teaming requires a good deal of communication, collaboration, and planning. To function successfully, teams also need leadership and direction. The early intervention team is led by the service coordinator, who keeps the team's activities focused on supporting the family and addressing the outcomes written in the child's IFSP. All team members, including the family, must be able to engage in open and honest communication about what supports are needed and how they should be provided, as well as challenges as they arise. Professional team members need to understand their roles, respect the opinions and roles of others, and collaborate across disciplines by sharing information and ideas and engaging in thoughtful discussions about how to best support the child's development within the context of the family. Frequent communication and regular meetings to share ideas and review the IFSP are important to keep the team cohesive and focused.

It is the job of service providers to ensure that families are supported, not overburdened. Therefore, effective teams offer supports in a competency-enhancing manner, which features these characteristics (Bricker, Pretti-Frontczak, Johnson, & Straka, 2002):

1. Mobilizing resources in ways that do not disrupt family life
2. Using supportive communication styles
3. Not overwhelming a family with information or services

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When team members fail to integrate these competency-enhancing characteristics into their interactions with families, problems can occur, which must be addressed in a timely and responsive manner. It is not uncommon for families to express concerns related to services being disruptive, providers not communicating enough with them, or feelings of being overburdened. When these problems occur, it is time for the IFSP team to pull together to identify a solution that results in services that better meet the needs of that child and family.

Problems with teaming have been reported in all disciplines, not just in education. Developing an effective team takes time; it is unrealistic to expect a team to work well together immediately or to expect a team to operate smoothly indefinitely. Being aware of other common team problems and how to manage them will help team members overcome challenges and collaborate effectively to resolve them.

Common Team Problems

The following are some common problems teams experience.

Differing Expectations About the Purpose of the Team and Team Members' Roles Understanding the purpose of the early intervention team is vital to the success of teaming. Problems will arise when staff and administrators do not share the same expectations about the team's purpose, duties, roles, and goals. Teams must come to a consensus on the team's family-centered mission if they are to operate effectively for the benefit of the child and family.

An effective team does not result from simply placing professionals from different disciplines in the same room. Team members with different discipline backgrounds have likely been trained in different missions, which may result in differing goals and solutions to problems. One common cause of conflicts in teams is having team members who have different expectations for the team or for the roles of team members. Team members may have been trained to focus on the child as the client rather than the family; thus, they may intend to provide child-centered rather than family-centered services. Some members may not have been trained in role sharing, which can make them uncomfortable or unfamiliar with addressing outcomes that they do not recognize as within their area of expertise. For example, a physical therapist might express discomfort with addressing outcomes that are not directly related to motor development. However, with the support of other team members, the physical therapist can come to understand how to support other areas of development, such as by talking or playing with a child while helping the child learn to plan motor movements that prepare for walking. Shared communication and support are essential to any team in which role sharing is an expectation.

Team Communication and Disagreements Poor communication is another common cause of problems in teams. Good communication is essential for every aspect of early intervention, including working in teams. The best teams are described as being relaxed with open, direct communication (Beninghof & Singer, 1992). Using conduct guidelines may improve communication during early intervention team meetings and may prevent a meeting from becoming contentious. Byington and Whitby (2011) suggested the following basic guidelines for communicating during team meetings:

- Allow one person to speak at a time.
- Focus all comments on the needs of the child and family.
- Listen and respect the opinions of others.

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- Encourage everyone to participate equally.
- Find solutions to issues.
- Be willing to respectfully compromise for the good of the child, family, and program.

Helping all team members honor these basic guidelines is typically one of the duties of the service coordinator. In the role of team leader, the service coordinator monitors team communication and collaboration for both successes and challenges related to the implementation of the IFSP.

All IFSP decisions include all team members, with the family members having the final say because they are in the best position to gauge their own needs. Teaming can be challenging when team members disagree on IFSP decisions, such as the type or frequency of services. Disagreements like these tend to be based on differing philosophies of intervention service delivery or different expectations for team member roles, particularly when role sharing is not a comfortable interaction style for all team members. A common understanding of the purpose and goal of early intervention, as covered in the key principles outlined in Chapter 1, and direct facilitation by the service coordinator can help early intervention teams navigate disagreements and come to a consensus.

Role sharing demands that team members have consistent and positive communication with one another. Maintaining a communication log, record, or notebook to track communications between team members can also be a useful tool (Byington & Whitby, 2011). Regular communication by phone, e-mail, online communication, or video conferencing is also necessary to ensure that strategies learned through role sharing continue to be used as intended.

Confidentiality Confidentiality must be strictly followed when communicating about families. Personal information about a child and his or her family must not be shared with anyone unless the family has given written consent for the release or exchange of that information. It is never permissible for a service provider to discuss information about one family with another family or a service provider who is not part of the team. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (PL 104-191) and the Family Educational Rights and Privacy Act (FERPA) of 1974 (PL 93-380) are laws that provide guidance related to confidentiality and must be followed in early intervention. Table 2.1 summarizes the nature of these legal requirements (U.S. Department of Health and Human Services & U.S. Department of Education, 2008).

Table 2.1. Privacy laws that affect early intervention

Law	Description
Health Insurance Portability and Accountability Act (HIPAA) of 1996 (PL 104-191)	Protects the privacy of personally identifiable information in health records May apply to early intervention programs that operate under health care providers and agencies, such as hospitals and other applicable community health agencies
Family Educational Rights and Privacy Act (FERPA) of 1974 (PL 93-380)	Protects the privacy of personally identifiable information in educational records May apply to early intervention programs that operate under agencies that receive funding under the U.S. Department of Education, such as public schools, school districts, and universities

Source: U.S. Department of Health and Human Services and U.S. Department of Education (2008).

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Challenges can arise among team members when there are limitations to what information can be shared. For example, a family may choose not to permit the sharing of information to certain team members, such as a child care provider or case manager from another community program involved with the family. When issues related to confidentiality affect team collaborations, the service coordinator can help the family understand why consent to share information is being requested and how sharing information can benefit the family or help the team operate within the limitations of communication.

Managing Team Conflicts

When conflicts are experienced, team members need to address the dispute directly and with professional courtesy. Team members must state a conflict as explicitly as possible, generate several ways for resolving it, and be open to the service coordinator's suggested solutions (Ostrosky & Cheatham, 2005). When disagreements occur, professionals need to remain calm, soften their voice, and permit the colleague with the concern to express his or her point of view. The key ingredient to resolving conflict with colleagues—and with parents or caregivers—is listening empathetically and making sincere efforts to come to a mutually acceptable resolution.

All team members want the same thing: what is best for the child and family. Listening empathetically involves trying to emotionally place one's self in the situation of another person and actively taking that person's viewpoint. When service providers acknowledge the legitimacy of someone else's point of view, negotiation will generally follow. Involving families as team members may lessen professional conflicts and discipline loyalties because the team is unified by families' priorities.

The objective of teaming is to access multiple perspectives to develop the best intervention plans for children. This involves input from a wide variety of professionals who are learning from one another (LaRocco & Bruns, 2013; Murray & Mandell, 2006).

Case Study: Mason

Mason's team was able to collaborate to solve a persistent problem his family had in the car. When the family rode in the van, Mason always cried, making the trip difficult for everyone. Had this problem been viewed from an isolated, discipline-specific perspective, the family might have been given conflicting suggestions. For instance, the special educator might have suggested they play music to calm Mason during the ride, and the physical therapist might have recommended that they keep the ride quiet with less stimulation. Instead, team members, including Mason's family, discussed the problem together and decided that the physical therapist would join the family for a car ride. During the ride, the therapist determined that Mason was becoming distressed by the light flashing in his eyes from the window. Mason was also having difficulty managing his head control in his car seat. Joining the ride revealed that the noise level in the car was not the issue at all. Based on these observations, the therapist and educator worked together with Mason's mother to develop solutions. They decided that covering the window with a shade and adding two small towel rolls on either side of Mason's shoulders would make the rides easier for him. These strategies reduced the light in his eyes and helped him support his head in a more comfortable position. These simple yet effective solutions were facilitated because Mason's team was able to share ideas across disciplines and engage in problem solving to meet Mason's family's specific needs.

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Innovative approaches and solutions often result from a team composed of diverse professionals discussing and working toward solutions based on the expertise of each team member. Effective early intervention teams learn to reach consensus by respecting diverse perspectives, assuming shared responsibilities related to a child and family's successes and challenges, and respecting the interaction between the family system and early intervention supports and services.

STRATEGIES FOR SUPPORTING TEAM COLLABORATION AND COMMUNICATION

Overcoming problems associated with team collaboration is the responsibility of all team members, especially those in a professional role. There are two mechanisms built into the early intervention team process that support team collaboration: the activities of the service coordinator and the IFSP meeting.

The role of the service coordinator has been viewed as "a linchpin to quality service delivery" (Harbin et al., 2004, p. 95). By actively monitoring service delivery and team collaboration, the service coordinator keeps abreast of family satisfaction, child progress, team cohesion, and successes or challenges with the implementation of the IFSP. The service coordinator maintains regular communication with and among all team members and documents these interactions in the child's intervention record. By communicating regularly with all team members, the service coordinator can link needs and resources in the most efficient manner. The activities of the service coordinator are critical for helping the family to navigate a positive intervention experience; without an actively involved service coordinator, services for families can seem disjointed or redundant or fail to follow the service plan as intended.

When the early intervention team faces a challenge or needs to communicate as a group, the service coordinator (or any other team member) can arrange an IFSP meeting. The IFSP team meets, in a face-to-face meeting or by other electronic means, to respond to changes in the child's development or family situation or to process any challenges or problems. The regularity of these team meetings depends on the needs of the team. The minimum standards for certain types of IFSP meetings are established in Part C of IDEA and are discussed in Chapter 3. IFSP meetings can occur at any time and for any reason, and they can be requested by any team member. They are a useful means of communication and collaboration for teams.

Between IFSP meetings, team members are encouraged to communicate regularly by sharing notes, discussing strategies, and collaborating to solve difficulties that arise based on the child's development, disability, or family situation. Regular communication among professional team members can be challenging with busy schedules and the isolation that comes with providing services outside of a single office location. Service providers are often out in the field, traveling from intervention visit to visit, and can go an entire workday or more without seeing another colleague. Staying in touch about a child's progress across services takes effort and can be managed by reading contact notes in the child's record and/or communicating by phone or e-mail with other team members between visits. Service providers who build in scheduled regular communication with team members find that it is often easier to do their job.

Early intervention team activities revolve around regular communication with families, as well as professional colleagues. Communicating well with families is critical to their role as active participants in the early intervention process and to their feelings of satisfaction. Good communication and collaboration among professional team mem-

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bers strengthens a team and builds positive relationships. Table 2.2 lists 14 strategies that service providers can use when communicating and collaborating effectively as part of an early intervention team. These strategies may be used with both colleagues and families.

Table 2.2. Communication strategies for effective collaboration

Strategy	Description
Explain collaboration and communication expectations to new team members.	Assist new team members with understanding what is expected of them as part of their participation on the early intervention team. When each person understands what is expected, the team is more likely to function well.
Ask team members about their preferred mode of communication.	Find out if families and colleagues prefer to be contacted by phone, e-mail, or text (if allowed by the early intervention programs) and honor that preference.
Check-in regularly with team members, especially the family.	Ask how they feel about intervention, whether or not they are having success with intervention strategies, and about any new needs. Families have reported that regular communication with service providers is key for collaboration.
Maintain a nonjudgmental, supportive attitude and manner.	Focus on child and family strengths and have a positive attitude about the family and other team members both in and outside of the family's presence.
Be honest and open.	Address needs or concerns expressed by the family or other team members in an unbiased manner. When needed, help families consider their options so that they can make informed decisions that are best for them. Avoid imposing professionals' viewpoints on the family.
Show that you are interested.	Use good eye contact and positive body language that shows that you are attending and interested, such as facing the speaker, leaning in toward him or her, and verbally acknowledging what is being said. Let the speaker know that his or her input is valued.
Schedule team meetings at places and times that are convenient for team members.	Schedule meetings when most, if not all, team members can participate. If a team member is absent, include information from that member to ensure that he or she has a voice.
Use language that all team members can understand.	Use language with families and other team members that is free of technical jargon. Define new terms when used in speech or in the body of the individualized family service plan or other reports.
Invite the family and other team members to share.	Invite families to share their priorities, concerns, and knowledge of their child during all team meetings. Help families feel that they have an active role and their opinion is respected. Ask for input from all members and be sure to consider all points of view when there is a decision to be made.
Use open-ended questions to gather information.	Use open-ended questions to gather information regarding a parent's or colleague's perspective on an issue or concern.
Follow through.	When a professional follows through, team members see that he or she is reliable. It is easier to collaborate with a trusted colleague.

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Strategy	Description
Communicate with team members with and without other team members present.	Join visits with other team members for collaboration. Find time to speak with team members in private. This is especially important when communicating with families to find out their satisfaction with intervention service providers, intervention strategies, and child progress.
Use interpreters when language barriers exist.	Ensure that families of differing cultural and linguistic backgrounds can understand and participate in team collaborations by providing information in the family's preferred language or mode of communication.
Use the child's record as a central repository of information.	Document all communication and activities with or on behalf of the child and family. Team members can then review the record to maintain supports and services.

One important communication strategy used with families and other professionals is the use of open-ended questions. *Open-ended questions* ask for information that cannot be answered in a few words or with a yes-or-no response. Because open-ended questions elicit complete responses, they are useful when more information is desired. Questions such as, "Tell me about why you feel that way," or "What makes Mason smile?" prompt a caregiver or colleague to give more elaborate and detailed responses. By gaining someone's impression first, open-ended questions allow service providers to be reflective and avoid jumping in and offering "solutions" before sufficient information is known. These kinds of questions also promote collaboration (shared problem solving) because they facilitate brainstorming, which is more likely to result in collaboratively designed interventions. How these effective communication strategies are implemented depends on who is on the team, individual preferences, state and local policies and requirements, and the leadership and teaming skills of professional team members.

BEST PRACTICE HIGHLIGHTS

The following best practices should guide service providers as they participate on early intervention teams:

- Using a family-centered approach to early intervention recognizes that each family is a unique, interconnected system, with the activities of each member affecting all others as well as the family unit as a whole.
- When early interventionists use family-centered practices, they understand that the child's parents and caregivers are the most important decision makers in the child's life and are the most important members on the early intervention team.
- Because early intervention is a relationship-based discipline, actively developing strong family–professional and professional-to-professional relationships and collaborations increases the chances of families participating in experiences that lead to positive outcomes for themselves and their child.
- Family members experience different reactions and ways of coping with a child's developmental delay or disability. While they are participating in early intervention, families are also negotiating a vulnerable time in their lives, so early interventionists must display empathy and patience.

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- Early intervention teams with a clearly delineated purpose—supporting each family's competence in promoting their child's development within everyday routines—tend to be more collaborative and, consequently, more successful teams.
- Innovative approaches and solutions often result from an early intervention team comprised of diverse professionals working collaboratively toward solutions based on the expertise of each team member.
- Effective teams use good communication with professional team members and families as they hold the team jointly accountable for helping families reach their identified outcomes for early intervention.
- The transdisciplinary team model, when used to conduct assessments and deliver competency-enhancing early intervention services, mobilizes resources in ways that do not disrupt family life, uses supportive and effective communication styles, and avoids overwhelming families with information or services.
- Successful early intervention teams communicate regularly with the service coordinator and other team members to ensure regular collaboration, have established ways for handling disagreements, and have a sense of shared responsibility for team success.
- The IFSP is used as the primary guide for all team decisions.

CONCLUSION

Mason's case study shows that early intervention can offer families a source of information, guidance, and emotional support during a time in which many families express that they feel overwhelmed, powerless, and unsure how to best support their child with special needs. The team members that worked with Mason worked collaboratively among themselves and with his family to develop a system of intervention supports that would immediately help the family members as they negotiated a very challenging time in their family's life. After much respectful dialogue, the team found a level of services that suited the family's lifestyle without overburdening them. After services began, Mason's primary service provider maintained regular interaction with the family and worked directly with the child care provider, Mason's three sisters, and occasionally, Mason's grandparents. The primary service provider also consulted regularly with the educator, and later with the speech-language pathologist, to ensure that he was well prepared to address all areas of Mason's development and Mason's IFSP outcomes.

Maintaining this collaborative communication made it easier for services to be adjusted when important events occurred in the family's life, including when Mason's mother eventually left her job and when a health crisis occurred with Mason that changed the family's most pressing needs for approximately 6 months. Because this transdisciplinary team had been systematic about how to work together, during the transition process near Mason's third birthday, his father described the family's experiences with early intervention in this way: "[Early intervention services] were a lifesaver for Mason and all of us. The encouragement and support were what I needed."

Early intervention provides a process that demands highly committed, professional, collaborative service providers who come together as a team to help families develop their own abilities in parenting their child. The quality of any early intervention program is determined by the quality of the disciplinary expertise, mutual respect, and communication skills of the team members. Effective teamwork permits interventionists to expand their individual knowledge as they offer support to parents who are learning ways to improve their child's development and learning.

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DISCUSSION QUESTIONS AND APPLIED ACTIVITIES

1. Identify five characteristics of family-centered practices and discuss in detail how they would be implemented during a 45-minute home intervention visit with a teenage single mother whose 6-month-old child, Toby, has global developmental delays. This mother lives with her parents in her family home. Both Toby's mother and grandmother are usually present for visits.
2. Name and discuss the 14 effective communication strategies that service providers use when collaborating with families and professional team members.
3. Role play a team meeting in which team members decide how they will conduct their IFSP meetings, which later will include a parent or caregiver. As a team, identify at least four guidelines for the team's meetings so they are positive, cordial, collaborative environments for team members as well as families. Come to a resolution that has consensus.

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