

The Top 10 Mistakes in Early Intervention in Natural Environments—and the Solutions

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Early intervention for children with disabilities is now commonplace, but bad habits have crept in. In this article I describe the top 10 mistakes early intervention providers make, and I offer some solutions. *Early intervention* here refers to the services operated under Part C of the Individuals With Disabilities Education Improvement Act (Public Law 108-446, 118 Stat. 2647); Part C refers to infants and toddlers with disabilities and their families. Sometimes, early intervention is used to refer to a broader range, such as children from disadvantaged backgrounds. Although I specifically refer to Part C, some of the mistakes and solutions indeed apply to the wider field of early childhood education.

Part C services are (a) multidisciplinary and multiagency and (b) family-centered. The first characteristic means that professionals from many different disciplines, such as early childhood special education, early childhood education, speech-language pathology, occupational therapy, and physical therapy, work in early intervention. Furthermore, these professionals might come from early intervention programs, health departments, home health agencies, rehabilitation departments in hospitals, and so on. The second characteristic should mean that professionals treat families in family-friendly ways, which, by and large, they do, and also attend to family-level (e.g., adult) needs, which, by and large, they don't (Turnbull et al., 2007).

Early intervention has been around for about 35 years but was only codified by

law in 1986, with the passage of Public Law 99-457; Education of the Handicapped Act Amendments of 1986). Since then, early intervention professionals have seen changes that have not advanced the field nor served children and families well. A fee-for-service method of paying for early intervention has led to purveyors of services scrambling madly for this new business. Because many of these service providers came from the medical model (actually, better tagged the "rehab" model), they established services in clinics instead of homes, they worked directly with children instead of their caregivers, and they were equally concerned with how to pay for services as with how well the child and family did. These kinds of changes have led to early intervention looking like John McKnight's (1996) "careless society," in which the roles of families and other natural caregivers are usurped by professionals. This change was forewarned as early as 1985 (one year before the law was

even passed) by Carl Dunst (1985), a pioneer in family-centered approaches to early intervention. Recently, we have heard calls to return to the conceptual roots of early intervention. The National Early Childhood Technical Assistance Center at the Frank Porter Graham Child Development Institute, which is at the University of North Carolina at Chapel Hill, convened a work group including nationally recognized early intervention experts (Workgroup on Principles and Practices in Natural Environments, 2007). This group asserted that the mission of early intervention was as follows: "Part C early

Abstract

Early intervention for infants and toddlers with disabilities and their families has strayed from its conceptual roots and the intent of the original legislation. The author describes the top 10 mistakes commonly made in early intervention, including what happens at intake, assessment, plan development, and delivery of services. He proposes five practices as a natural-environments approach to fixing these mistakes. The essence of this alternative approach is to recognize natural caregivers, such as parents and child care providers, as intervention agents and to ensure children are getting valid interventions.

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Part C services are family-centered.

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" (p. 2). The seven principles they also agreed upon elaborate on the key pieces of this mission: supports are more than services, and assistance goes to adults, who help children in everyday routines—not in set-aside, specialized times and places. Those routines can be in homes, child care, or early-childhood classrooms.

Changes in the field and the recent appeal to go back to the original intent of early intervention provide the backdrop to the top 10 mistakes being made in early intervention.

The Top 10

THE MISTAKES LISTED here are my personal irritations, gleaned from spending hours with practitioners and directors across the U.S.

1. DOING ALL THE TALKING AT INTAKE VISITS

Intake visits are the first visits by early intervention personnel to a family. The professionals have much to do at these visits: describe the program, get financial information, find out about medical concerns, determine whether the child has an established condition, determine whether the child will need to be tested for eligibility, ask the family for consent to evaluate, and so on. These questions are all quite bureaucratic, meaning that they are largely for the benefit of the agency—to get paperwork completed so the family can participate in the program.

2. ASKING FAMILIES ABOUT DAILY ROUTINES AT EVERY MEETING LEADING UP TO PLAN DEVELOPMENT

Early interventionists have known for a long time that capturing information about what a child does in a typical day might give some insight to functional needs for intervention, so they have asked about daily routines, at one level or another, at intake, at the evaluation, and sometimes even at the individualized family service plan (IFSP) meeting.

Families hate having to repeat information. Apart from being tiresome, it makes them feel that professionals, at best, aren't communicating or, at worst, aren't listening.

3. BASING GOALS ONLY ON WHAT PARENTS SAY THEY WANT

In their desire to be family-centered, professionals often ask parents what their main concerns are so these concerns can be turned into outcomes (i.e., goals) on the IFSP. This well-meaning question is usually asked after a child has been tested and found to be eligible on the basis of delay or after the program has documentation that the child has an established condition.

When parents answer this question, they have little basis for giving a well-thought-out answer, so they either try to deflect the question back to the professionals (e.g., "What do you think I should be concerned about?") or they mention the most obvious areas of infant or toddler development: talking and walking—or the steps leading up to talking and walking. That's why IFSPs on average have fewer than three outcomes, therefore missing many other functional needs the child might have and, just as important, the needs of the parents related to the child's development and learning. Many IFSPs are still shockingly child-oriented instead of family-oriented (Jung & McWilliam, 2005).

4. IGNORING THE PARTICIPATION PURPOSE OF CHILD-LEVEL GOALS AND SKIMPING ON MEASURABILITY OF GOALS

Why do early interventionists address deficits in child functioning? They sometimes lose sight of the purpose of intervention. The child's acquisition of a skill isn't an end in itself; it's a means to participation in home, "school," and community. To ensure early interventionists really improve functioning, therefore, it's imperative that they keep the purpose of the behavior at the forefront of the intervention. Otherwise, they might teach the child the skill without applying it to a functional context, rendering it a pretty useless skill. The second part of this mistake refers to the fact that many IFSP outcomes are not clearly measurable: It's hard to tell how one judges progress or whether the outcome (think goal) has been attained.

5. MATCHING SERVICES TO DEFICITS

In many communities, services are decided on the basis of the child's diagnosis or what he cannot do. Because this decision is not based on the support that people already working with the child actually need, it leads to a pile-on of services that (a) overwhelms natural caregivers, (b) often produces a fragmented intervention plan, and (c) is very costly, thus reducing the opportunity to meet unmet needs such as families who need more visits, children who need child care subsidized, and so on.

6. WORKING DIRECTLY WITH THE CHILD ON HOME VISITS

The most common setting for early intervention services is the home, and most home visitors have adopted a clinic-based approach and dumped it on the living room floor. That is, they spend most of their time working directly with the child (Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007).

This approach means the child essentially receives intervention only when the home visitor is there, whereas, if the home visitor were to work with the parents, the child could receive intervention when the home visitor isn't there, which of course is much more of the time. Therefore, direct, hands-on work with the child during a home visit is actually underserving a child and family.

7. MODELING OR DEMONSTRATING BLINDLY

Early interventionists sometimes delude themselves into believing they're working with children to demonstrate techniques for families in the home or teachers in the classroom. If they simply interact with the child, without letting the caregiver know they're modeling a technique, however, it is unlikely the caregiver will pay attention to the early interventionist's purported demonstration. That means it's unlikely they will imitate the demonstration later, when the early interventionist isn't there.

This can be considered the model and pray approach: You model and pray that the caregiver will imitate. It is a mistake because it wastes the opportunity to demonstrate effectively and, simultaneously, might lead the caregiver to the erroneous conclusion that the hands-on work was real intervention.

8. USING THE SAME HOME VISITING APPROACH FOR ALL FAMILIES

Home visitors who go into home after home with toy bags, working with children, are missing the opportunity to meet actual needs in the family. If they have good, functional IFSPs, they have meaningful topics to discuss with families. A support-based, responsive approach to home visiting means

that addressing those topics will result in very different kinds of home visits (McWilliam & Scott, 2001).

9. FOCUSING EXCLUSIVELY ON THE CHILD'S WELL-BEING AND QUALITY OF LIFE

Family systems theory makes it clear that the well-being of one member of the family affects the well-being of other members of the family (Bronfenbrenner, 1986). To be effective in early intervention, therefore, early interventionists need to attend to the emotional, material, and informational support needs of the parents (Guralnick, 2007).

10. WORKING ONLY WITH CHILDREN IN CLASSROOMS

For a similar reason that working directly with children on home visits is a mistake, when early interventionists visit children in group care, they sometimes take the child to the side of the classroom and work with the child on predetermined skills. This work is not related to the ongoing classroom routines, so the teachers pay little attention—which they might as well do, considering the early intervention isn't doing anything relevant to ongoing classroom life, in this scenario. Some early interventionists even take the child out of the classroom and provide therapy or instruction totally out of sight of the teachers.

These one-on-one in classroom (McWilliam, 1996) or pull-out models prevent teachers from learning techniques they could use during all those hours when the early interventionist isn't in the classroom.

Solutions

THESE 10 MISTAKES can be fixed by adopting five practices that constitute a natural-environments approach to early intervention (McWilliam & Er, 2003; Workgroup on Principles and Practices in Natural Environments, 2007). The five practices, described below, consist of constructing an ecomap, conducting Routines-Based Interviews (RBI), identifying a primary service provider, offering support-based home visits, and consulting collaboratively in the classroom.

Ecomap

The first solution is to conduct an ecomap with the family at the intake visit. This will offset Mistake 1, talking too much, and Mistake 2, asking families repeatedly to talk about daily routines.

An ecomap is a drawing of the nuclear family and their extended family, friends, neighbors, professionals, agencies, recreation opportunities, employers, and religious groups. These are informal, formal, and intermediate supports (Ray & Street, 2005).

More important, perhaps, than the product is the process—the conversation between the intake coordinator and the parent, as the coordinator draws the map. As each member of the network is mentioned, the professional asks questions to determine the level of support (e.g., “How often do you talk to them?” “How well do you get along with her?” “Do you like him?”). Although when written down here, these questions might seem intrusive, families understand the general idea of constructing the ecomap. Their answers to the support level questions determine the thickness of the lines the professional uses to connect the network member to the nuclear family. The whole process takes only 10–15 minutes.

Ecomaps give the family the opportunity to talk about themselves, even if it's for just a short while. It counterbalances all the information the intake professional has to give—all that talking. Constructing an ecomap provides important information about the family, without getting into their routines. The intake coordinator is not asking about routines, knowing that, at a subsequent contact, the family will be asked about routines in a detailed way. Developing ecomaps therefore helps with Mistakes 1 and 2. For more information about conducting an ecomap, see McWilliam (2010b) and Ray and Street (2005).

Routines-Based Interview

The solution to Mistake 3, basing goals only on what parents say they want, is to conduct an RBI with the family (McWilliam, Casey, & Sims, 2009). The interview typically is done between the determination of eligibility and the completion of the IFSP. The purposes of the RBI are to develop a positive relationship with the family, to obtain a rich and thick description of child and family functioning, and to obtain a list of family-chosen functional outcomes (goals) for the child and family.

The interviewer asks the family about their main concerns and then asks questions to gather in-depth information about what the family and child do during each time of the day (i.e., activity, event, routine). The questions are about what the whole family does; about the child's engagement, independence, and social relationships; and about the family's satisfaction with the routine. The interview ends with the interviewer reminding the family about the concerns or desires they mentioned in the discussion of each routine. The family then lists what they want to work on with the team—the outcomes—and they put them in priority order.

When parents are first asked what they want, they have little structure for answering. After going through an RBI, they have thought carefully through the functional needs of the



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day and are well equipped to list 6–10 outcomes to go on the IFSP.

FUNCTIONAL OUTCOMES

These outcomes are therefore highly functional for the child and family and must now be written in such a manner that progress and accomplishment can be measured (McWilliam et al., 1998). They address Mistake 4, which is ignoring the participation purpose of child-level outcomes or goals and skimming on the measurability of outcomes or goals.

The solution is found in seven steps of functional outcome writing:

1. Read the shorthand version of the outcome from a family-centered, functional needs assessment (e.g., RBI).
2. Find out what routines this affects.
3. Write “Child will participate in [the routine(s) in question]”.
4. Write “by _____ing,” addressing the specific behaviors.
5. Add a criterion for demonstrating the child has acquired the skill.
6. Add another criterion for generalization, maintenance, or fluency, if appropriate.
7. Add the amount of time given for accomplishing the goal.

An example of an outcome addressing play with toys during hanging-out times is “Tyrell will participate in hanging-out times at home by playing with toys. We will know he can do this when he plays with a toy for 5 minutes, independently, 3 times in 1 week.”

Learn More

MY EARLY INTERVENTION IN NATURAL ENVIRONMENTS BLOG

<http://naturalevironments.blogspot.com>

My Early Intervention in Natural

Environments blog covers a variety of topics on this issue. Recent posts have been about toddler groups, how to address autism from a natural-environments perspective, and the RBI with families of recent neonatal intensive care unit graduates.

SLIKIN CENTER FOR CHILD AND FAMILY RESEARCH

www.slikinresearch.org

The Slikin Center for Child and Family Research conducts applied research on children's development and functioning to discover effective and innovative methods of intervention with children and families. This Web site has many resources related to the routines-based model.

NATIONAL EARLY CHILDHOOD TECHNICAL ASSISTANCE CENTER

www.nectac.org/topics/natenv/natenv.asp

The Natural Environments page of the National Early Childhood Technical Assistance Center includes *Key Principles and Practices for Providing Early Intervention Services in Natural Environments*. The Technical Assistance

Community on Part C Settings is found at www.tacommunities.org/community/view/id/1029.

MISSOURI'S DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

[www.dese.mo.gov/divspeed/FirstSteps/](http://www.dese.mo.gov/divspeed/FirstSteps/EITTEAMpage.htm)

[EITTEAMpage.htm](http://www.dese.mo.gov/divspeed/FirstSteps/EITTEAMpage.htm)

The Early Intervention Teams page of Missouri's Department of Elementary and Secondary Education shows the history of Missouri's movement to teams, their definition of teams, various question and answer documents, and brochures.

ORLEANS HAWES PUCKETT INSTITUTE

www.puckett.org

The Web site of the Orleans Hawes Puckett Institute contains many resources related to enhancing healthy child, parent, and family functioning. This is the Institute Carl Dunst founded with his long-time collaborator, Carol Trivette.



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Working with adult family members builds intervention skills throughout the week.

Writing participation-based goals addresses directly the problem of goals that might address a skill but that don't improve a child's engagement (McWilliam & Casey, 2008) in a meaningful, normal routine. As shown above, the various criteria make the child-level outcomes highly measurable. With family-level outcomes, one criterion is usually enough. For more information about the RBI, see McWilliam (2010a, 2010b) and McWilliam et al. (2009).

Primary Service Provider

Mistake 5 is matching services to deficits, leading to a pile-on of services, which is especially likely in states using a vendor approach to services. The solutions to this mistake are found in how service decisions are made, how services are provided, and the roles service providers are prepared to play.

INCREMENTAL DECISION MAKING

This method of making decisions about services adds services only as necessary, rather than assigning a service to every need. The premise is that well-trained early interventionists can meet a variety of needs, not just a narrow set of needs aligned with their original training. The incremental decision-making procedure begins with the assumption that one professional is assigned to the child and family as the primary provider. The team then adds only services needed to address outcomes the primary provider and the family need additional help with. For example, if a child is delayed in talking, but the primary provider and

the parent know how to teach him to talk, there is no need to add an ongoing service. When a service is added, the team plans a level of intensity needed to ensure that the regular caregivers and the primary provider have the information necessary. These additional services are for information—it's a consultative approach—not working directly with the child. Even in a clinic, which is not a natural environment, the clinician needs to use the child as the vehicle for teaching the family how to intervene with the child. The child is getting intervention from regular caregivers, such as parents and teachers (McWilliam, 2003). Incremental decision making prevents the pile-on of services by adding only services that are necessary.

ONE MAIN PROVIDER

Integrated services focus the support provided to families, rather than diffuse them across multiple professionals. Teamwork is ensured by having one professional through whom team members work, like a funnel. This person can be a regular home visitor, a classroom teacher, or a classroom consultant. When a funnel approach is not used, services are in silos (everyone doing his or her own thing, irrespective of others) or scattershot (disparate, unconnected people working with the same family). The primary-service-provider model is defined as one professional providing weekly support to the family, backed up by a team of other professionals who provide services to the child and family through joint home visits with the primary service provider. The intensity of joint home visits depends on child, family, and primary-service-provider needs.

The use of a primary service provider prevents the pile on of services by having one professional as the ongoing support who views the whole child and family, seeking help as needed. For more information about the use of a primary service provider, see Hanft, Rush, and Sheldon (2004), McWilliam (2003), and Woodruff and Shelton (2006).

Support-Based Home Visits

Four mistakes are addressed through support-based home visits:

1. Working directly with the child,
2. Modeling or demonstrating blindly,
3. Using the same home visiting approach for all families, and
4. Focusing exclusively on the child's well-being and quality of life.

Support-based home visits consist of providing emotional, material, and informational support (McWilliam & Scott, 2001). Suggestions are based on child and

family functioning in routines and require a good set of functional outcomes. The home visitor goes down the list of 6-10 outcomes, in the family's priority order, although in any one visit perhaps only a few outcomes are addressed. To address each outcome, the home visitor gets the family's perception of how things have been going, determines what the family would like the child or family to be able to do during specific routines, listens for a discrepancy between the demands of the routine and the abilities or interest of the child, assesses what the family has already tried, gives information about potential interventions, assesses the family's interest in learning the specifics of the interventions, and, if the family is interested, teaches the intervention to the family. The Vanderbilt Home Visit Script (McWilliam, 2010b) can be useful in reminding home visitors to take a routines- and support-based approach. The script consists of the following questions:

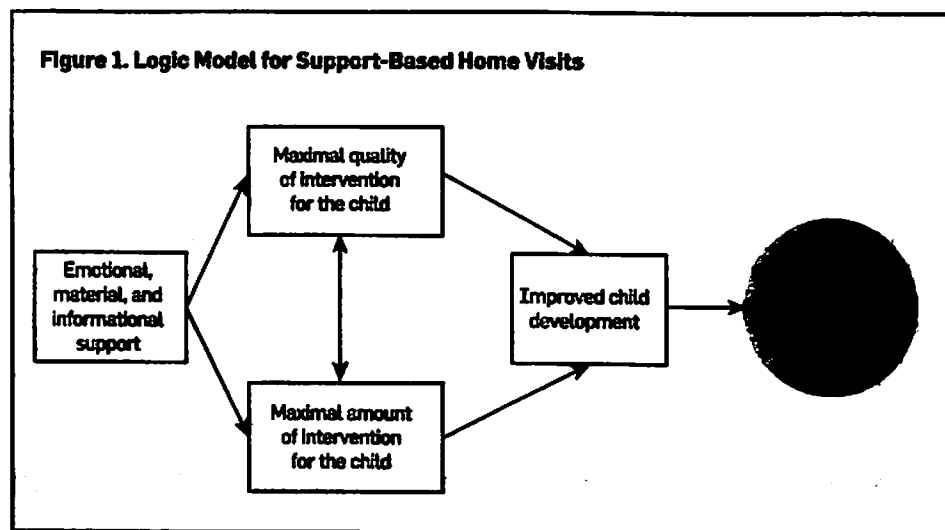
1. How have things been going?
2. Do you have anything new you want to ask me about?
3. Review of outcomes in priority order.
4. Is there a time of day that's not going well for you?
5. How is [family member] doing?
6. Have you had any appointments in the past week? Any coming up?
7. Do you have enough or too much to do with [your child]?

By adopting the consultative approach inherent in these home visits, the home visitor works directly with the adult family members, rather than the child, so the family has the intervention skills to use throughout the week. Furthermore, talking to the parents makes sure that adult-level needs are also addressed. These home visitors use modeling as a technique only in the context of providing information to families and they customize each visit to the family's individual needs and preferences; this happens by getting the family's perceptions, determining what the family would like the child or family to be able to do, listening, assessing what the family has already tried, and so on. Finally, focusing on the results of the RBI and conducting home visits in such a family-centered manner allows the home visitor to focus on the family's quality of life. The logic model for support-based home visits is shown in Figure 1.

Collaborative Consultation to Child Care

The tenth mistake, working only with children in classrooms, refers to classroom

Figure 1. Logic Model for Support-Based Home Visits



consultants, including therapists, early interventionists, and itinerant teachers, who interact with children directly, hands-on. The solution to this mistake is to use a method that provides more intervention to the child—integrated services, focusing on services that are individualized within routines and group activities, two evidence-based approaches to consultation (Horne & Mathews, 2004).

Integrated specialized services are when therapy and special instruction occur in the classroom with other children usually present and in the context of ongoing routines and activities, when the teaching staff can learn from the consultant. The purpose is to ensure the teaching team has the knowledge and skills to be able to maximize the child's meaningful participation in everyday routines (Noell et al., 2005). Providing intervention that is individualized within routines is a technique in which the consultant joins the child in whatever the child is engaged in that is part of the regular classroom routines and weaves his interventions into that interaction. Group activity occurs when the consultant conducts an activity for the whole class or a group, for the benefit of an individual child. In both of these techniques, the teaching staff is present, watching, and helping, so they can learn the interventions to apply later on (McWilliam, 1996). The use of a collaborative, integrated approach to seeing children in child care involves working with adults in classrooms, often by demonstrating with children. For more information about collaborative consultation, see McWilliam (1996, 2010b) and Rush, Shelden, and Hanft (2003).

Discussion

THESE MISTAKES AND solutions are consistent with the mission and guiding principles set out by the Workgroup on Principles and Practices in

Natural Environments (2007). I must self-disclose that I was part of that Workgroup. As stated previously, this collection of supposed experts in early intervention in natural environments arrived at the following mission statement: "Part C 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" (p. 2). Deconstruction of this statement makes some points apparent. First, early intervention should add to and strengthen the informal supports families of young children already have. It should not set up interventions in isolation of the resources families already have. Second, early intervention should ensure children and their families have access to information and actual materials that will foster child and family development. Information and materials can come through formal services (e.g., special instruction, physical therapy, occupational therapy, speech-language pathology), but early intervention should not be limited to services (Dunst, Trivette, & Deal, 1994). Third, early intervention was designed to assist the adults in a child's life, not the child. This distinction is a hard pill to swallow for many well-meaning early interventionists, who have devoted their careers to children or those who are afraid that this diminishes the amount of attention children will receive. As this article should have made clear, however, the point is that children will actually receive more help and more relevant help if interventionists support the adults. Fourth, interventionists are focused on the ultimate improvement of children's functioning. Adult competence and confidence are the proximal outcomes of the work (i.e., what interventionists directly affect) and child learning and development are the distal outcomes of the work (i.e., what interventionists affect as a function of adult competence and confidence). Fifth,

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interventions should occur in naturally occurring places, in naturally occurring routines, and from the child's natural caregivers (e.g., parents, teachers). Urie Bronfenbrenner (1977) wrote, "much of contemporary developmental psychology is the science of the strange behavior of children in strange situations with strange adults for the briefest possible periods of time" (p. 257). Although he was writing about research, the same could be said for they way many early intervention services are provided. Children do become used to their weekly early interventionists, so those people are no longer