NATIONAL GUIDELINES

BEST PRACTICE IN EARLY CHILDHOOD INTERVENTION

ecia

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The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular clients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing.

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1 : BACKGROUND

What is Early Childhood Intervention?

Early Childhood Intervention (ECI) is the process of providing specialised support and services for infants and young children with disability and/or developmental delay, and their families, in order to promote development, well-being and community participation www.ecia.org.au

Tim Moore, leading expert in ECI, states that the overall aim of ECI is to ensure that the parents or other key caregivers are able to provide young children who have disability and/or developmental delay with experiences and opportunities that promote the children's acquisition and use of competencies which enable the children to participate meaningfully in the key environments in their lives (2012).

ECI practitioners work in partnership with parents/caregivers, families and other significant stakeholders to enhance their knowledge, skills and supports to meet the needs of the child, optimise the child's learning and development, and the child's ability to participate in family and community life (Bruder, 2010; Dunst, 2007).

Why are the early years Important?

The early childhood years lay the foundation for all future development. Recent scientific evidence shows that early experiences shape our lives by affecting the way the young brain develops. What happens to us in the early years has a major effect on our health and social development through to adulthood. Therefore, we must ensure that children's early experiences are positive - that they have a secure foundation for development. (Sameroff, 2009; Shonkoff, 2010; Shonkoff & Phillips, 2000; Sroufe, 2009; Worthman et al., 2010).

The early childhood years are just as important for children with disability and/or developmental delay as they are for all children. All their future development is based on the critical learning patterns laid down during this period.

The early years are also critical for the whole family. This is when families can best begin to learn how to support and nurture their child, how to meet their child's needs, and how to adapt positively to having a child with disability and/or developmental delay.

The Early Intervention Seven Key Principles: Looks Like/Doesn't Look Like

The Early Intervention Seven Key Principles: Looks Like/ Doesn't Look Like presents in plain language best practice principles and their application for infants and toddlers in ECI settings. The seven universal principles identified are:

1

Infants and toddlers learn best through every day experiences and interactions with familiar people in familiar contexts.

2

All families, with the necessary supports and resources, can enhance their children's learning and development.

3

The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child's life.

4

The early intervention process, from initial contacts through to transition, must be dynamic and individualised to reflect the child's and family members' preferences, learning styles and cultural beliefs.

5

Individual Family Service Plan outcomes must be functional and based on children's and families' needs and priorities

6

The family's priorities, needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support.

7

Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations. (WPPNE, 2008)

This document is endorsed by the NDIA and can be accessed on the NDIA website.

Early Childhood Intervention Australia (ECIA)

Early Childhood Intervention Australia is the peak body for early childhood intervention in Australia, representing professionals and organisations that provide services for young children with disability and/or developmental delay and their families.

Early Childhood Intervention under the National Disability Insurance Scheme

ECI services in Australia will henceforth be delivered via the National Disability Insurance Scheme (NDIS) under the auspices of the National Disability Insurance Agency (NDIA) the independent statutory agency whose role is to implement the NDIS or possibly the Disability Service Commission (WA only) depending on the outcome of an independent evaluation.

The NDIS is new to disability service provision in Australia and provides a set of agreements that ensures that there is a single consistent scheme for the provision of disability support services across all Australian states and territories. It provides funding directly to individuals who are able to choose their own services and purchase directly from providers. The NDIS will essentially mean the end to 'block funding' from government to service providers. It is expected that the scheme will be fully operational in most jurisdictions and the sector transition complete by the year 2019-20.

The NDIS enables participants to access reasonable and necessary supports, including early intervention, with more choice and control over how, when and where supports are provided.

ECIA considers early childhood intervention as supporting a child's development of functional skills that would enable them to participate meaningfully in everyday activities alongside typically developing peers. Early childhood intervention supports need to be provided in a way which is inclusive of the family so that activities are targeted to encourage the learning and development of the child and are reinforced and complemented in family settings. In this sense, the goals of the family, their values and priorities need to be integral to the developing early intervention approach to ensure that ECI will make the most significant impact (ECIA, NSW Chapter, 2014).

Rationale - National Guidelines for Best Practice in Early Childhood Intervention

Current practices in ECI in Australia vary across and within states and territories. As a national scheme, the NDIS requires national guidelines for best practice that may be consistently applied in all states and territories.

The purpose of these guidelines and recommendations is to provide a framework for universal and equitable high quality ECI based on best practice for children with disability and/or developmental delay whether they attend government, non-government, large, small, sole non-for-profit service providers or private providers, anywhere in Australia.

Development Phase of the National Guidelines for Best Practice

These guidelines and recommendations draw upon extensive consultation with the ECI sector and key stakeholders.

In May and June 2015, ECIA undertook a series of consultation workshops across Australia. The starting point for discussions with the ECI sector on the best practices in ECI was the Early Intervention Best Practice Discussion Paper developed by ECIA in 2014. This paper was distributed as pre-reading for the National Guidelines consultation workshops.

The objectives of these workshops were to:

- review current practice in Early Childhood Intervention across Australia;
- identify key best practices in ECI that are agreed upon by the ECI sector and its stakeholders across Australia;

- identify any environmental factors impacting upon current ECI practice;
- identify strategies to address gaps between current ECI practices and best practice in ECI

Over 400 participants attended these workshops in eleven diverse locations across Australia. Locations included Geelong, Melbourne, Sydney, Newcastle, Canberra, Brisbane, Rockhampton, Darwin, Perth, Adelaide and Hobart. Eleven submissions from key organisations on the Guidelines on Best Practice were also received. The workshop reports make for a unique insight into the state of practice in early childhood intervention across the country. Please go to the ECIA National website to view the Emerging Themes Reports for each of these workshops.

The feedback provided to ECIA during the consultation phase of the National Guidelines project was then cross-referenced against Australian and international research and literature in Early Childhood Intervention.

The final consultation was engagement with the Expert Advisory Group (EAG) which consists of 60 experts in a diversity of fields related to ECI. They were asked to critically review the final draft document.
For a full list of the EAG members go to: www.ecia.org.au/advocacy/eci-national-guidelines-project

From the review of current literature and extensive consultation with the ECI sector, four quality areas were identified comprising of eight key recommended best practices in ECI which are found on the following page. The rationale for each of these best practices can be found in Section 3: Rationale for Key Best Practices in ECI (p.8).

2 : KEY BEST PRACTICES IN EARLY CHILDHOOD INTERVENTION

From a review of current international and Australian literature and extensive consultation with the ECI sector, four quality areas were identified comprising of eight key best practices in Early Childhood Intervention (ECI).

Quality Area 1: Family

1. **Family-Centred and Strengths-Based Practice:** is a set of values, skills, behaviours and knowledge that recognises the central role of families in children's lives. Family-centred practice is a way of thinking and acting that ensures that professionals and families work in partnership and that family life, and family priorities and choices, drive what happens in planning and intervention. Family-centred practice builds on family strengths and assists families to develop their own networks of resources – both informal and formal.

2. **Culturally Responsive Practice:** creates welcoming and culturally inclusive environments where all families are encouraged to participate in and contribute to children's learning and development. Practitioners are knowledgeable and respectful of diversity and provide services and supports in flexible ways that are responsive to each family's cultural, ethnic, racial, language and socioeconomic characteristics.

Quality Area 2: Inclusion

3. **Inclusive and Participatory Practice:** recognises that every child regardless of their needs has the right to participate fully in their family and community life and to have the same choices, opportunities and experiences as other children. All children need to feel accepted and to have a real sense of belonging. Children with disability and/or developmental delay may require additional support to enable them to participate meaningfully in their families, community and early childhood settings.

4. **Engaging the Child in Natural Environments:** promotes children's inclusion through participation in daily routines, at home, in the community, and in early childhood settings. These natural learning environments contain many opportunities for all children to engage, participate, learn and practise skills, thus strengthening their sense of belonging.

Quality Area 3: Teamwork

5. **Collaborative Teamwork Practice:** is where the family and professionals work together as a collaborative and integrated team around the child, communicating and sharing information, knowledge and skills, with one team member nominated as a key worker and main person working with the family.

6. **Capacity-Building Practice:** encompasses building the capacity of the child, family, professionals and community through coaching and collaborative team work. The goal is to build the knowledge, skills and abilities of the individuals who will spend the most time with the child in order to have as great an impact as possible on the child's learning and development.

Quality Area 4: Universal Principles

7. **Evidence Base, Standards, Accountability and Practice:** ECI services comprise practitioners with appropriate expertise and qualifications who use intervention strategies that are grounded in research and sound clinical reasoning. Standards based on these ECI key best practices will ensure ECI practitioners and services are accountable to continuous improvement and high quality services.

8. **Outcome Based Approach:** focuses on outcomes that parents want for their child and family, and on identifying the skills needed to achieve these outcomes. ECI practitioners share their professional expertise and knowledge to enable families to make informed decisions. Outcomes focus on participation in meaningful activities in the home and community with outcomes measured and evaluated by ECI services from a child, family and community perspective.

3 : RATIONALE FOR KEY BEST PRACTICES IN EARLY CHILDHOOD INTERVENTION

From a review of current international and Australian literature and extensive consultation with the ECI sector, four quality areas were identified comprising of eight key best practices in Early Childhood Intervention (ECI). The rationale for each of these best practices is detailed below.

Quality Area 1: Family

1. Family-Centred and Strengths-Based Practice: is a set of values, skills, behaviours and knowledge that recognises the central role of families in children's lives. Family-centred practice is a way of thinking and acting that ensures that professionals and families work in partnership and that family life, and family priorities and choices, drive what happens in planning and intervention. Family-centred practice builds on family strengths and assists families to develop their own networks of resources – both informal and formal.

> *Within Australian and international ECI literature, family-centred and strengths-based practice are considered best practices (Dew et al. 2014; Fordham et al. 2012). There was broad consensus across the ECI National Guidelines consultation workshops on these practices and that family-centred practice, in particular, is the foundation for best practice in Early Childhood Intervention.*

Family-Centred Practice

Family centred practice is made up of a set of values, attitudes and approaches for working in partnership with children and their families. Family centred practice is not just a specialist way of working with a child with disability and/or developmental delay, and their families, but is now established best practice for anyone working with children and families. In fact, it has rapidly emerged as the preferred model for working with people of all ages and circumstances.

There is now strong evidence for the approach, including that it improves child behaviour and wellbeing, family functioning, levels of social support available to families and family satisfaction with services, and that it contributes to these primarily by increasing parental self-efficacy (Dempsey & Dunst, 2004; Dempsey & Keen, 2008; Gavidia-Payne et al., 2015; Guralnick, 2011). Importantly, family-centred practice, is indirectly linked to improved developmental outcomes for the child, through building the self-efficacy of the family (Dunst & Trivette, 2009). The approach is also supported in school settings by evidence of the benefits of family–school partnerships for all students (DHS & DEECD, 2012).

Family centred practice recognises that:

- Each family is unique and different.
- The family is the constant in the child's life.
- The family is the expert on the child's abilities and needs.
- Optimal child functioning occurs within a supportive family and community context; the child is affected by the stress and coping of other family members.

Guiding principles of family centred practice:

- Each family should have the opportunity to decide the level of involvement they wish in the decision making for their child.
- Parents have ultimate responsibility for their child.
- Each family and family member should be treated with respect.
- The strengths and needs of all family members should be supported and encouraged.

(Law et al., 2003; CCCH, 2004. DHS & DEECD, 2012).

As children learn in the context of their families, families are the primary influence on children's learning and development (Bruder, 2010; DEECD, 2011). A key role of ECI is to support parents/caregivers and educators to enable them to provide children with experiences and opportunities that promote using and developing their skills (Moore, 2012). Families, educators and community partners who feel respected and supported by ECI practitioners and who feel competent in the skills needed to interact with the child are better able to promote a child's social, cognitive and behavioural developments (Gavidia-Payne et al., 2015).

A model developed by Dunst, Trivette and Deal (1988) on enabling and empowering families has influenced the thinking about family centred practice for decades. The model has since been expanded to a Helpgiving Practices model (Dunst 2010; Dunst & Trivette, 2009; Dunst et al., 2007) which identifies three key components of effective capacity-building family-centred helpgiving:

- Relational practices build relationships and are about the help giver's beliefs, values and attitudes, and their interpersonal behaviours and skills.

- Participatory practices are where the help giver empowers families to make informed decisions and take action, and ensures that the help giver responds to each family's unique and changing needs.

- Technical quality is about the help giver having the information, knowledge and expertise needed to deliver high-quality supports and services, and applying it for the benefit of children and families.

Research and clinical practice have increasingly indicated that how help is provided is as important as what is provided if help giving is to have positive consequences (Dunst & Trivette, 2009; Dunst et al., 2007). The ability of ECI professionals to support families depends not only on their technical knowledge and skills in working with children with disability and/or developmental delay, but also upon their personal qualities and skills in building positive working relationships with parents and supporting family's choice and participation (Moore, 2012).

Providing family-centred services can be a challenge to some practitioners. Family-centred practice does require a shift in power and authority away from the professional as 'expert' and key decision-maker and towards the family. In fact, additional expertise is required to empower families (DHS & DEECD, 2012).

Partnering with families and communities to support a child to learn, grow and thrive is an integral part of family-centred practice. ECI professionals share their professional expertise and knowledge with the family and at the same time regard the family's expertise as valid, significant and valuable. They position themselves as knowledgeable consultants who support families' choices and values. Providing families and their social supports with information can, in itself, enable families and other key stakeholders to make choices and decisions (Bailey & Powell, 2005; Fordham et al., 2012).

Strengths-based practice

All families, with the necessary supports and resources, can enhance their children's learning and development (WPPNE, 2008).

Strengths-based practice builds on family members' competencies; supports families to make decisions for themselves; and focuses on empowering families to do things for themselves within their social communities. Rather than focusing on correcting peoples' weaknesses or problems, capacity-building and strength-based strategies recognise the assets and talents of people and help people use these competencies to strengthen functioning (Caspe & Lopez, 2006; Dunst & Trivette, 2009; Dunst, 2007).

For the child, strengths-based practice means that ECI practitioners focus on what each child can do, or shows emerging ability to do in different contexts, and on the opportunities these afford, rather than what the child is not able to do and potential barriers to development (ECIA, NSW Chapter, 2014).

Effective ECI services build on the existing strengths of children, families and the communities in which they interact. Focusing on existing strengths promotes an individual's sense of control and is integral to facilitating empowerment (Dempsey & Dunst, 2004). ECI services that adopt a strengths-based practice are more effective and empowering to families and community stakeholders leading to better long-term outcomes (Green et al., 2004). For the ECI practitioner, it also requires an awareness and understanding that all families are resourceful but do not always have the ability or knowledge to access the resources and supports they require.

Increasingly, ECI practitioners are faced with families with complex and multiple needs. All families, including families of children with disability and/or developmental delay, face a range of factors that can compromise parental, personal and family functioning. These include factors such as housing, finances, transport, social support, parental/caregiver physical and mental health, drug and alcohol issues and family violence (Moore, 2012). The presence of one or more of these factors can undermine parents' and caregivers' abilities to address their children's needs, and is particularly so for families with complex cultural backgrounds such as Aboriginal and Torres Strait Islander and migrant families (Guralnick, 2011).

It is imperative that these risk factors and needs are addressed in a holistic manner in order to affect any meaningful and sustainable change, improve family functioning and ensure the child has the required supports. If these factors are not addressed, they will undermine the family's capacity to put supports around their child and jeopardise achievement of positive outcomes.

The essential task for ECI practitioners in delivering family-centred and strengths-based programs is to identify the strategies and experiences that will suit the needs and circumstances of a particular family, and to work with the family to build these strategies into their everyday life (Dunst & Trivette, 2009; KPMG, 2014; Guralnick, 2011; CCCH, 2011; Moore, 2012). The ECI practitioner must have a good knowledge of the community system so that they can link families into appropriate universal services and then to provide assistance to support these services to accommodate the needs of the family and child if necessary. An important point for practitioners to remember is that families do have the right to make choices for themselves and their child unless they contravene the law.

2. **Culturally Responsive Practice:** creates welcoming and culturally inclusive environments where all families are encouraged to participate in and contribute to children's learning and development. Practitioners are knowledgeable and respectful of diversity and provide services and supports in flexible ways that are responsive to each family's cultural, ethnic, racial, language and socioeconomic characteristics.

> *In all of the consultation workshops, culturally responsive practices or cultural competencies were highlighted as an important best practice. It was acknowledged that ECI practitioners need to be more culturally responsive and culturally competent to work effectively with the diversity of families across Australia. Respecting diversity of families was noted as a key feature central to family-centred practice.*

Culturally responsive practice and family-centred practice are deeply linked because culture profoundly shapes both human development and family structures, whatever a family's culture. Children's personal, family and cultural histories shape their learning and development (DEECD, 2011). A family's culture may also affect attitudes, values, beliefs and capacities across a number of areas including: child-rearing practices; health practices; meanings of disability; perceptions of education; and perceptions of ECI (Madden, 2005).

Family-centred practice requires services to take into account each family's socio-cultural and socio-economic related expectations for development and participation (Dew et al., 2014). Families are less likely to participate or stay engaged with ECI services when their cultural background is ignored (CCCH, 2011).

Culturally responsive practice is when professionals and organisations respond respectfully and skilfully to the needs of diverse communities. It can be seen as part of a broader concept of cultural competence, described as a set of 'congruent behaviours, attitudes and policies that come together in a system or agency or among professionals' that enable effective work in cross-cultural situations (National Medical and Health Research Council in DHS & DEECD, 2012). A lack of adequate cultural competencies, including personal maturity and thoughtfulness in outlook and practice, ability to achieve functional therapeutic outcomes with interpreters, ability to work with community leaders/educators and use translated resources effectively is a significant barrier to working with culturally and linguistically diverse families and Aboriginal and Torres Strait Islander families (Dew et al., 2014; Lindsay et al., 2012).

Translation and interpretation services for families where English is not their first language is an important part of being culturally competent. Where possible an appropriately skilled interpreter should be offered to avoid difficulties that might arise from having family members or friends interpret. However, family preferences must be considered and there may be occasions where it is most appropriate for a family member or friend to interpret. Other needs and priorities of the family should be respected in the selection of the interpreter - factors such as the interpreter's gender and religion may also be important (Madden, 2005).

Recognising the complexities contributing to a family's diversity, respecting the family's personal and social resources and being able to cater to diversity are key features of family-centred practice (Dew et al., 2014). Understanding the practices, values, beliefs and cultures of families, and the immediate and extended communities in which they interact are fundamental to the best practice of ECI.

Quality Area 2: Inclusion

3. Inclusive and Participatory Practice: recognises that every child regardless of their needs has the right to participate fully in their family and community life and to have the same choices, opportunities and experiences as other children. All children need to feel accepted and to have a real sense of belonging. Children with disability and/or developmental delay may require additional support to enable them to participate meaningfully in their families, community and early childhood settings.

> *There was broad consensus across all ECI National Guidelines consultation workshops on the importance of inclusion. The Early Childhood Intervention Australia (ECIA) and Early Childhood Australia (ECA) 2012 statement, 'Position on the Inclusion of Children with Disability in Early Childhood Education and Care', has contributed to raising people's awareness of the rights of children with disability and/or developmental delay to be included not only in Early Childhood Education and Care settings (ECEC) but in all aspects of community life. However, there is still work to be done to enable children to participate meaningfully in inclusive settings and have a 'sense of belonging.'*

Inclusion is the active participation of children with and without additional needs, within their family, early childhood programs and community settings. Children spend the majority of their time with their families in everyday routines and activities (Bruder, 2001; Jung, 2003). Their main learning environment is the family, with community settings and early childhood programs playing an increasingly important role as they grow older. Inclusion is not just about children with disability and/or developmental delay attending mainstream programs, but about creating environments for all children to be able to develop relationships, have opportunities enabling meaningful engagement and participation in all activities (DEECD, 2011; ECIA, NSW Chapter, 2014;). Participation is more than being present in different environments –it means being actively engaged. For participation to be meaningful, the person's role and contribution must be valued by all those involved in the activity, including the person themselves (Moore, 2012).

Children with disability and/or development delay benefit from interacting and participating in activities and settings with children without disability (Bruder, 2010; Case-Smith & Holland, 2009; CCCH, 2011). Research has demonstrated that children with disability are more interactive in inclusive settings than in segregated settings providing greater opportunities for children to develop friendships (Antia et al., 2011; Case-Smith & Holland, 2009). Children without disability also experience positive outcomes in inclusive settings (CCCH, 2011).

Successful inclusion of a child depends upon the attitudes and beliefs of all concerned: parents, ECEC staff, children, and community members. In fact, attitudes, assumptions and beliefs of community members are perceived by individuals with disabilities to be the single greatest barrier to their achievement of life goals (King et al., 2002). However, a wide variety of other factors also influence the way in which inclusion is implemented and viewed by families and practitioners such as child and adult characteristics, and policies and resources (King, 2006). A collaborative project by ECIA and ECA to develop a joint position statement on the inclusion of children with disability in ECEC settings found that the beliefs, attitudes and values of early childhood practitioners were seen as key to successful inclusion of children with disability and/or developmental delay. Staff were more likely to remain negative about inclusion if they felt inadequately trained and supported to provide inclusive programs. Training and support for staff to work effectively with children with disability was linked to improved attitudes by respondents (Forster et al., 2013).

The NSW's Strengthening Supports for Children and Families 0-8 Years: Now and Into The Future (FACS, 2015) reflects on the first three years of the strategy saying that:

> *'there has been a strong focus on changing culture and practice within the disability sector. We need to continue to build a culture where mainstream community settings, including family support, early childhood education and care, Family and Community Services, education and health settings, are the natural context for young children and their families, with early intervention supports merged within these settings to develop inclusive communities. We will know we have made progress when families and mainstream settings work in partnership to co-produce outcomes aimed at improving a child's life in the context of their family and meaningful participation in their community.'*

For inclusion to be successful, families, early childhood service providers and community service providers must be provided with specialist support to meet their needs, and to enable them to help children develop the skills to participate meaningfully in everyday activities. There is clear evidence that, without purposeful adaptations and strategies, children with disability are not involved in as many activities as other children (Odom et al., 2011; National Professional Development Center on Inclusion, 2011; CCCH, 2014). Ensuring participation involves using a range of intervention approaches to promote engagement and a sense of belonging for each child (Buysse, 2012).

Assisting caregivers to develop positive and responsive relationships with their child with disability and/or developmental delay from as early an age as possible should be a major focus of early childhood intervention services. Support can include direct support from ECI practitioners, ongoing professional development, collaboration and co-ordination among key stakeholders, public policies and resources, and research and evaluation (Buysse, 2012). For inclusion to be effective, service providers must ensure that all aspects of program design, including policies, laws, institutions, services, facilities and technologies are developed on principles of universal design (Darragh, 2007). All programs need to build their capacity to cater for all children, and provide supports across the complete spectrum of abilities, cultures, and circumstances (ECIA, NSW Chapter, 2014).

4. Engaging the Child in Natural Environments: promotes children's inclusion through participation in daily routines, at home, in the community, and in early childhood settings. These natural learning environments contain many opportunities for all children to engage, participate, learn and practise skills, thus strengthening their sense of belonging.

> *There was broad consensus across all ECI National Guidelines consultation workshops on engaging the child in natural environments- however, respondents strongly recommended that the terms 'natural learning environment' and 'working with a child through daily routines' be clarified for use by the Early Childhood and Early Childhood Intervention sectors.*

Natural environments are settings, where children learn and develop everyday abilities and skills, including the home, community, and early childhood centres (Dunst & Bruder, 2006). Natural environments are full of opportunities for children to practise, master and expand their skills and learning (Sandall & Schwartz, 2008). Learning skills in a natural environment is more effective than practising a new skill in an isolated setting once or twice a week (Case-Smith & Holland, 2009; Dunst et al., 2010b).

Delivering interventions in natural environments involves the people who are part of the children's lives (FACS, 2015). Children's ongoing learning depends upon having repeated opportunities to practise developmentally appropriate skills in everyday situations with support from caregivers and community members (WPPNE, 2008).

The way in which parents and caregivers engage children is critical for their overall development (Dunst, 2006; Dunst & Swanson, 2006; Karaasian & Mahoney, 2015). Promoting responsive caregiving is therefore an essential first step in ensuring that children build secure relationships with caregivers and early childhood service providers. Engaging children by capturing their interests creates opportunities to sustain learning, supports current competencies and facilitates development of new competencies (CCCH, 2014; Davis, 2014; Dunst & Bruder, 2006). Children are active participants in their own development and active involvement builds understanding of concepts, creative thinking and the inquiry processes necessary for lifelong learning (McWilliam, 2010a; DEECD, 2011).

Interventions are more effective when they reflect everyday activities and routines such as getting dressed and mealtimes (Bruder, 2010; Dunst et al., 2010; McWilliam, 2010a). The sequence of routines and their repeated nature provide opportunities for children to acquire and refine skills (Hughes-Scholes et al., 2015). In the context of everyday routines, a good facilitator can incorporate additional learning opportunities reflecting individual goals and interests (Campbell et al.; 2009).

Parents prefer interventions that are meaningful, easy to do, fit into their daily lives, and support their child in learning skills that help them be part of family and community life (Dunst et al 2010). When parents provide intervention in daily routines they are more likely to attribute progress to what they do between home visits, rather than to what the professional does during a home visit (McWilliam, 2010a; McWilliam, 2010b).

Quality Area 3: Teamwork

5. Collaborative Teamwork Practice: is where the family and professionals work together as a collaborative and integrated team around the child, communicating and sharing information, knowledge and skills, with one team member nominated as a key worker and main person working with the family.

> *There was broad consensus across all ECI National Guidelines consultation workshops that collaborative and coordinated teamwork was an essential best practice for ECI. Currently under the NDIS, best practice teamwork in ECI is defined as 'transdisciplinary family centred key worker' or a 'transdisciplinary service model early childhood intervention.' However, because the word 'transdisciplinary' has now become more closely associated with a 'funding line' than a model of team interaction teamwork, we now understand the need to define collaborative teamwork practice and related terminology so there is consistency across Australia. This work has been initiated in a research paper developed for the NDIS by Moore (2013) 'Team work in early childhood intervention services: recommended practices.'*

Below we describe how current teamwork models have developed over time and then define concepts essential to collaborative teamwork with 'collaborative teamwork' the preferred teamwork model that best reflects contemporary practice. It is a flexible, easily understandable model of teamwork interaction that will best meet the needs of families and, not only the ECI sector, but major partners in the ECEC sector, education, health and family support areas as they increasingly engage with providing supports to children and their families under the NDIS.

Teamwork Models of Interaction

Providing families with choice and control is central to the NDIS. This extends to providing families with a choice of provider, including the potential for families to bring together a team of providers who can deliver the range of required supports in the ways, places and at the times that best match their family's needs. Children with disability and/or developmental delay may require the combined expertise of a range of practitioners and specialised services including medical personnel, therapeutic practitioners and educational and developmental experts. There are a range of approaches to 'teamwork' including multidisciplinary, interdisciplinary, transdisciplinary and, more recently, the key worker and Team Around the Child (TAC) models with 'collaborative teamwork' combining some of the key elements of the transdisciplinary, the key worker and the TAC teamwork models.

Multidisciplinary Teamwork

In multidisciplinary teams, a range of professionals work independently with the child and have limited interaction with one another (Briggs, 1997). Specialists conduct their own assessments, develop their own set of goals and provide interventions directly with the child. The advantage of this model is that it maximises the specialist skills of the different professionals. However, the lack of co-ordination means there is a high risk of professionals providing contradictory advice and of making cumulative demands upon families that are unrealistic and highly stressful (Moore, 2013). Lack of communication between team members also places the burden of coordination and case management on the family.

Interdisciplinary Teams

Interdisciplinary teams comprise parents and professionals from several disciplines who have formal channels of communication (Briggs, 1997). Representatives of various professional disciplines assess children and families separately, but the team meets to discuss the results of assessments and develop plans for intervention. Generally, each specialist is responsible for the part of the service plan related to his or her professional discipline. Although this approach solves some of the problems associated with multidisciplinary teams, families are not consistently recognised as equal team members and coordination of services continues to be a problem. There is evidence that families find the constant rotation of visits from different professionals confusing and stressful (Moore, 2013).

Transdisciplinary Teams

Transdisciplinary team practice means that the family and professionals work together as a collaborative team sharing information, knowledge and skills across disciplinary boundaries, with a key worker coordinating and doing most, if not all, of the intervention. Families themselves are valued members of the team and are involved in all aspects of the process. All decisions in the areas of assessment and program planning, implementation and evaluation are made by team consensus (Briggs, 1997; Woodruff and McGonigel, 1988).

Benefits of a transdisciplinary team include: a coordinated approach; service efficiency; cost effectiveness of services; less confusion for the family; more coherent intervention plans and holistic service delivery and the facilitation of professional development that enhances therapists' knowledge and skills building collective competence (King et al., 2009).

Role release is a feature of the transdisciplinary model. The key worker uses some direct intervention strategies from outside their discipline with supervision and support from relevant team members. 'Role release' allows the family to interact primarily with a key worker, who works in consultation with other team members, to create a coordinated service for the families. Through multiskilling and role release, all team members including the family develop 'shared meaning', which improves the effectiveness of the intervention for the child and family (Davies, 2007). However, this sharing of roles across disciplinary boundaries (and giving up) technical skills is the most challenging aspect of transdisciplinary practice because of perceived disciplinary boundaries and regulatory issues.

The Key Worker

The Key Worker may be described as a Case Worker, Transdisciplinary Key Worker, Key Contact or Primary Service Provider. For this document the term 'key worker' will be used.

Research indicates that what parents prefer is a single point of contact with services and an effective, trusted person to support them get what they need (Drennan et al., 2005). An effective way to approach this challenge is to use a key worker model of service delivery (Alexander & Forster, 2012; Luscombe, 2010; Greco et al., 2004; Shelden & Rush, 2013).

The key worker acts as the conduit for the expertise of the whole team in most situations and uses transdisciplinary skills to do so. Where skills-based specialist intervention is required, the relevant team members should be involved. Although sharing many similarities with the transdisciplinary team model, the key worker model is seen as an enhancement of this model, but differs from the transdisciplinary model in some important ways (Moore, 2013).

The key worker focuses on working with significant adults in the child's life, imparting information, knowledge and skills to them by using coaching and consultation rather than only direct therapy with the child.

The key worker focuses on the child's natural learning environments using the child's daily routines and activities to promote the child's development and participation rather than working with the child solely in a clinical setting.

Team Around the Child

The Team Around the Child (TAC) (Limbrick, 2001, 2004, 2005, 2009) is a teamwork model developed in the UK and has been adapted in Australia in a number of states. TAC is a systems way of coordinating early interventions for children and families who have complex needs and require interventions from a number of practitioners. The TAC model incorporates capacity building and evidence-based practices including: family-centred practice; strengths and interest-based practices; and the natural learning environment (Luscombe, 2010).

Features of TAC include: each child's key practitioners agree to work as a closely collaborative and well organised team; a key worker is the main point of contact for a family and is primarily responsible for coordinating intervention; families are equal and valued members of the TAC and are involved in all aspects of decision-making and intervention; support is continuous and seamless (Limbrick, 2005). As noted by the Victorian Government, 'there is a strong evidence base supporting the TAC approach as an effective way for a range of services to engage collaboratively and positively with families' (DEECD, 2014).

Key Features of Collaborative Teams

Collaborative teamwork is a teamwork model that is flexible and combines some of the key elements of the transdisciplinary, key worker and TAC teamwork models into a workable model for today and into the future. It is easily understandable and identifiable for families and all the key stakeholders in ECI and the community.

Family members and professionals work together as a collaborative, integrated, coordinated team with the common goal of facilitating participation of a child and family in everyday community environments. Communication is crucial, contributing to problem solving, consensus decision making and other aspects of teamwork. Together team members develop shared: understanding, responsibility and vision.

Families are always central to the team and are the final decision makers. Other team members are invited, according to the specific needs and wishes of the family. Team members can include extended family, ECI service providers, private practitioners, ECEC educators, school teachers, paediatricians, and other adults whose skills and opinions make important contributions to the team. Over time, as the needs of the family and child change, team membership also may change.

A key worker, chosen by the team, coordinates information, services and supports. Family members sometimes assume the key worker role although, most often, they chose a professional to be the key worker. When the key worker is a professional, that person is the family's contact, providing much of the service to the child and family. Indirect work, such as coaching of the adults who facilitate participation of the child or family in everyday community environments, is a major form of service delivery. As the main service provider, the key worker must draw on the skills and knowledge of other team members.

Although not all team members directly provide intervention to a child or family, all share knowledge and expertise that informs implementation, planning and monitoring of services. A benefit of working in a collaborative team is the expanded knowledge and expertise that all members gain from sharing and reflecting with other team members. Shared knowledge and responsibility also contribute to a greater sense of satisfaction with one's work.

Skills for a Key Worker in Collaborative Teams

A key worker as part of a collaborative team (and in the transdisciplinary, the key worker and TAC models who use a key worker), needs to have both expertise and experience in ECI practice to work effectively in the key worker role. They:

- work with families and other significant adults and apply evidence-based parent and parenting support using adult learning practices such as coaching and building on relationships based on trust and respect;
- need a sound base of the skills and knowledge of their own profession;
- require a sound understanding of child development, and;
- consult with other team members and children's services.

(Shelden and Rush, 2013; Alexander and Forster, 2012).

6. **Capacity-Building Practice:** encompasses building the capacity of the child, family, professionals and community through coaching and collaborative team work. The goal is to build the knowledge, skills and abilities of the individuals who will spend the most time with the child in order to have as great an impact as possible on the child's learning and development.

> *There was broad consensus across all ECI National Guidelines consultation workshops on the importance of capacity building using principles of adult learning. Adult learning principles, which is the base of capacity-building practices is seen as a skills area that needs to be developed by the ECI sector.*

Capacity-building practices support parents, caregivers, professionals and communities by using their existing abilities and developing new skills (Dunst & Trivette, 2009; CCCH, 2011). For families, this means that the ECI professional works in a collaborative partnership recognising what families do well already, and progressively building their capacity to meet the needs of their children and other family members. For early childhood professionals and other community partners, it means that the ECI professional builds on their existing skills, knowledge and abilities through coaching and collaborative teamwork which will then increase their capacity for working with the child with disability and/or developmental delay.

Capacity-building help-giving practices have a positive impact on a child's learning and development (Bruder, 2010). Children spend a very small proportion of their awake time in ECI activities (Bruder, 2010; Dunst & Bruder, 2006; Moore 2012). Therefore, it is essential to build the capacity of parents, caregivers and other significant adults who spend the most time with the child (Bruder, 2010). Capacity building practices are effective in increasing parents and caregivers' self-efficacy, beliefs of their parenting abilities - their sense of confidence and competence (Dunst & Trivette, 2009; Bruder, 2010; CCCH, 2011).

Coaching, which is a form of capacity building, is an effective way to develop parent/caregiver and educator capabilities and has been defined as: An adult learning strategy in which the coach promotes the learner's ability to reflect on his or her actions as a means to determine the effectiveness of an action or practice and develop a plan for refinement and use of the action in immediate and future situations (Shelden & Rush, 2010).

Coaching facilitates an exchange of information between the ECI practitioner and family and where the ECI practitioner and parent/caregiver or educator jointly problem solve and reflect on current practices and address challenging situations (Shelden & Rush, 2010). Coaching provides opportunities to learn and practice new strategies (Shelden & Rush, 2010).

ECI professionals need skills in communication and knowledge transfer – helping other adults understand and use what they know. These are the complementary skills of coaching, consultation and collaboration (CCCH, 2014). However, practitioners are not always adequately trained or prepared to work with adults and other practitioners either working in: the consultant's role (special education teachers and therapists) or as the consultee (parents, teachers and teacher's aides) (Buysse & Wesley, 2007).

When ECI professionals work together to support families/caregivers, early childhood educators and other community partners to achieve outcomes for the child, they are learning from each other through exchange of knowledge and skills. Networks are developed that can be accessed for future opportunities, hence creating a sustained strengthened service system to support families and children.

Quality Area 4: Universal Principles

7. **Evidence Base, Standards, Accountability and Practice:** ECI services comprise practitioners with appropriate expertise and qualifications who use intervention strategies that are grounded in research and sound clinical reasoning. Standards based on these ECI key best practices will ensure ECI practitioners and services are accountable to continuous improvement and high quality services.

> *There was broad consensus across all ECI National Guidelines consultation workshops on the importance of universal principles. Participants felt strongly that the NDIS which involves a mix of private providers, not-for-profit service providers and government providers as well as new service providers that all professionals delivering ECI services across Australia adhere to a common set of national standards and accountability measures. These standards must be based on sound evidence and research.*

Timely, accessible and equitable services for all families, in particular, vulnerable families is of particular significance. Soft entry points to ECI services such as supported play groups, early childhood education and care services, child and maternal health services is critical. Referral processes that target Aboriginal and Torres Strait Islander families, culturally and linguistically diverse families and rural and remote families also are important for ensuring equitable services for all.

These ECI best practice guidelines based on strong evidence and research and supported by wide consultation across Australia were seen as an important first step to provide the base for further work in the development of standards for the ECI sector.

[1] Much of the available research and evidence in early childhood intervention originated outside of Australia. While the best practices espoused in this work resonates with Australian culture, there is a need for validation by research conducted locally.

Evidence-Based Practice

'Evidence-based practice is a decision-making process that integrates the best available research evidence with family and professional wisdom' (Buysse and Wesley, 2006). In other words, evidence-based practice involves a balance of empirically supported interventions, clinical expertise or practice wisdom, and client or family values, preferences and circumstances (CCCH, 2014).

To ensure that they are working from a base of evidence informed by the latest research and practice, ECI practitioners should maintain knowledge and skills through lifelong continuing professional development. ECI also requires ongoing review and monitoring to ensure that practices are achieving the desired outcomes. ECI practitioners become more effective through critical reflection and a strong culture of professional enquiry (DEECD, 2011). Ongoing self-reflection, self-assessment and monitoring of practices are at the centre of the proposed development of practice standards.

The role of direct intervention by specific professionals

In addition to the body of evidence for the ECI sector there are also other bodies of evidence that suggest specific intervention for children with specific needs, such as cerebral palsy and autism spectrum disorder that lead to improvement in childhood development and skill development. This is particularly evident in disability- specific evidence. This evidence should be taken into account when providing services to young children. However, any specific intervention with young children should always be provided through the context of family centred principles, inclusive of coaching, and incorporated into everyday routines and settings. Therefore, providing ECI does not exclude the provision of specific targeted interventions, it is the way in which these interventions are provided and supported which is critical (ECIA, NSW Chapter, 2014).

Legislation

Legislation underpins all the Best Practice Principles of Early Childhood Intervention. The UN Convention on the Rights of the Child (UNICEF, 1990) states that children with disability share universal rights with all people, and additional rights accorded to all children. The specific rights of children with disability are expressed in the UN Convention on the rights of persons with disabilities (UN, 2006). Among other international statements, the UNESCO Salamanca Statement (UNESCO, 1994) on inclusive education recognises the importance of inclusion of children with disability in mainstream education. Australia has its own legislation, at both national and state and territory levels, which supports both the rights of children with disability and the inclusion of children with disability (HREOC, 1986–2004).

Quality and Accountability Safeguards

A national consultation process to inform development of the NDIS Quality and Safeguarding Framework was recently completed. The proposed Quality and Safeguarding Framework aims to make sure the NDIS scheme will provide good quality supports and will maximise the choice and control of participants (NDIS, 2015). Under the NDIS, Governments will no longer be purchasing specialist disability services and therefore the current quality assurance arrangements and some of the safeguards will no longer apply (NDIS, 2015). This dictates a greater need for national consistency and a quality and safeguarding framework –that is mandating participation in an external quality assurance system.

Feedback received from the ECI sector and stakeholders during the consultation phase of the ECI National Guidelines project overwhelmingly supported the need for an external quality assurance system as proposed in the NDIS Quality and Safeguarding framework. This option would require ECI service providers to undertake a rigorous quality assurance and improvement process to meet recognised industry governance and management standards and achieve certification/registration with a recognised certification/accreditation body.

Timely, Accessible and Equitable Services

The following four system problems were found to impact upon children with disability and/or developmental delay access to ECI services: lack of early identification; lack of easy access; lack of timely access and lack of full access (CCCH, 2011).

These system problems are linked to delays and waiting lists for assessments; lack of universal assessments; eligibility requirements; availability of services and practitioners and, in some cases, of culturally sensitive services and practitioners. The effectiveness of ECI is impacted both by the timeliness of identification and the timeliness of accessing an ECI service (CCCH, 2011; CCCH, 2004). Early identification leads to more benefits from ECI strategies targeted towards their needs (Bruder, 2010; KPMG, 2014).
 Research has shown that due to the nature of human brain plasticity, the earlier the intervention, the larger the impact on outcomes (Hadders-Algra, 2011).

Equity requires that each child, regardless of ethnic and cultural background, receives the support and resources needed to participate, engage and succeed. Families of children with the highest need for services are less likely to use them (CCCH, 2011). Soft entry points through non-targeted and non-stigmatised services, such as playgroups, provide a non-threatening setting for vulnerable and marginalised families to begin to engage with ECI services (CCCH, 2011).

Families with children with disability and/or developmental delay living in rural and remote areas lack information about the types of support that they need and are more likely to have difficulty accessing disability supports (Dew et al,. 2013). There is a shortage of therapists living and working in rural and remote areas of Australia (Dew et al., 2012; Dew et al., 2013; Fordham et al., 2012). This shortage means that families are significantly disadvantaged in accessing ECI compared with families living in urban areas (Dew et al., 2012). Further disadvantage is experienced by Aboriginal and Torres Strait Islander people as 46% live in outer regional, remote or very remote areas in Australia, and are twice as likely as non-Indigenous Australians to experience profound or severe restriction in activity and participation (Dew et al., 2012). Further challenges for families include: irregular outreach; distance to services; families' access to transport; and child care or respite care (Dew et al., 2012; Fordham et al., 2012).

One of the most significant challenges for delivering ECI services in rural and remote areas in Australia is recruiting and retaining practitioners (Dew et al., 2012). The lack of training, support, supervision, opportunities to work in a team, opportunities for career advancement and the amount of travel often required are difficulties faced by rural and regionally based practitioners (Dew et al., 2012). Access to continuing professional development and supervision and mentoring from experienced Allied Health practitioners can assist in retention of these practitioners and attract and retain new graduates (Lincoln et al., 2014). Research also suggests an increase in the use of technology and locally-based trained therapy assistants may improve access to services for families in rural and remote areas (Dew et al., 2012).

8. Outcome Based Approach: focuses on outcomes that parents want for their child and family, and on identifying the skills needed to achieve these outcomes. ECI practitioners share their professional expertise and knowledge to enable families to make informed decisions. Outcomes focus on participation in meaningful activities in the home and community with outcomes measured and evaluated by ECI services from a child, family and community perspective.

> *There was broad consensus across all ECI National Guidelines consultation workshops on this best practice. However, there were different levels of understanding in the workshops of what an 'outcomes-based approach' was and what constituted a 'functional outcome.' More work will need to be done by the ECI sector in developing these understandings and also in the assessment of the suitability of existing outcome measurement tools that ECI services can use to evaluate the effectiveness of their services.*

Outcome-focused approaches moves ECI services away from focusing on their service outcomes to focusing on the impact the service is having on children, parents/caregivers and families (CCCH, 2011). Outcomes are defined by Gavidia-Payne et al. as "those benefits that children experience in ECI programs so they become active and successful participants across a variety of settings" (2015). The three main outcomes for children relate to:

1. their social-emotional wellbeing;

2. acquisition and use of knowledge and skills; and

3. use of appropriate behaviours to meet needs.

Family outcomes are also considered essential to effective ECI service provision (Gavidia-Payne et al., 2015). Family-related outcomes include: increased sustainability of everyday routines; greater advocacy skills; sufficient family and social supports; decreased parental stress; increased family quality of life; greater empowerment; and more information about and access to other community services and resources (Llewellyn et al., 2010; Ziviani et al., 2010).

Outcomes should always be individualised and reflect the contextual needs of children and families. Increasingly outcomes are now set by families and are functional and meaningful for the child with disability and/or developmental delay and their family. Since families and other caregivers are the ones who will be seeking to incorporate interventions into their daily interactions with children, it is critical that they value the outcomes being sought. The process whereby the outcomes that will be addressed are identified is one in which the parents' views, values and circumstances are acknowledged, the professionals share their perspectives, and an initial set of outcomes that are valued by the parents are agreed upon (ECIA, NSW Chapter, 2014).

Focusing on functional outcomes and participation in meaningful activities builds on the intrinsic motivators of children and families and is, therefore, more likely to lead to success (WPPNE, 2008). A focus on outcomes provides ECI services with a basis for planning service delivery, allows flexibility to respond to individual needs and helps to identify the processes and data needed for monitoring, evaluation and continuous improvement.

To ensure that ECI services are effective, they need to measure and evaluate the impact of their strategies (Dew et al., 2014; CCCH, 2011). Outcomes being measured and evaluated should include both child and family outcomes (Bailey et al., 2006). The International Classification of Functioning Disability and Health (ICF) provides an important framework for assessment, intervention planning and evaluation of child-based outcomes (Cerniauskaite et al., 2011). Service provision should address all aspects of this framework, focussing on activity, participation and the environment. Ecocultural theory (e.g. Llewellyn et al., 2010) provides an important framework for considering the sustainability of everyday routines for families and in other contexts in which children participate. Ideally, service providers document both short- and long-term outcomes of services as well as factors that enabled or prevented delivery of the intended services (formative evaluation).

4 : CONCLUSION

The development of these National Guidelines for Best Practice in Early Childhood Intervention in ECI is very timely as the introduction of the NDIS has provided the impetus for change and made it more important than ever to ensure consistent high quality ECI service is provided for families and their children with disability and/or developmental delay in this new competitive market-driven environment.

These guidelines and recommendations draw upon extensive consultation with the ECI sector and key stakeholders and from advice received from an Expert Advisory Group. The advice provided to ECIA during the consultation phase of the Early Childhood Intervention National Guidelines project was then cross-referenced against Australian and international research and literature in Early Childhood Intervention. So with these guidelines and the subsequent development of Standards for ECI, families and their children with disability and/ or developmental delay can be confident that the supports they access for their child will be of a high standard wherever they are located throughout Australia.

5 : REFERENCES

Alexander, S. and Forster, J. (2012). The Key Worker: Resources for Early Childhood Intervention Professionals. Malvern, Victoria: Noah's Ark Inc.

Antia, S. D., Jones, P., Luckner, J., Kreimeyer, K. H., & Reed, S. (2011). Social outcomes of students who are deaf and hard of hearing in general education classrooms. Exceptional Children, 77(4), 489–504.

Bailey, D.B., & Powell, T. (2005). Assessing the information needs of families in early intervention. In Guralnick, M.J. (Ed.), A Developmental Systems Approach to Early Intervention. Baltimore, MD: Brookes Publishing Co.

Bailey, D. B., Bruder, M. B., Hebbeler, K., Carta, J., Defosset, M., Greenwood,C. & Kahn L. (2006). 'Recommended outcomes for families of young children with disabilities.' Journal of Early Intervention vol.28, no.4, pp.227-251.

Briggs, M.H. (1997). Building Early Intervention Teams: Working Together for Children and Families: Gaithersburg, Maryland: Aspen Publishers.

Bruder, M. B. (2010). 'Early childhood intervention: A promise to children and families for their future', Exceptional Children, vol.76, no.3, pp.339-355.

Bruder, M. B. (2001). Infants and toddlers: Outcomes and ecology. In M. J. Guralnick (Ed.). Early childhood inclusion: Focus on change. Baltimore, Maryland: Paul H. Brookes

Buysse, V. (2012). Access, participation, and supports: A framework for improving inclusive early education opportunities for children with disabilities. In R.C. Pianta, W.S. Barnett, L.M. Justice and S.M. Sheridan (Eds.). Handbook of Early Childhood Education. New York: Guildford Press.

Buysse, V. & Wesley, P. (2007). Consultation in early childhood settings. Paul H Brookes Publishing, Marylands.

Buysse, V. and Wesley, P.W. (2006). Evidence-Based Practice in the Early Childhood Field. Washington, DC: Zero to Three.

Campbell, P. H., Sawyer, L. B., & Muhlenhaupt, M. (2009). 'The meaning of natural environments for parents and professionals', Infants & Young Children. vol. 22, no.4, pp.264-278.

Caspe, M. and Lopez, M.E. (2006). Lessons from Family-Strengthening Interventions: Learning from Evidence-Based Practice. Cambridge,

Case-Smith, J. & Holland, T. (2009). 'Making decisions about service delivery in early childhood programs', Language, Speech, and Hearing Services in Schools, vol.40, pp.416–423.

Centre for Community Child Health (CCCH). (2014). Strengthening Inclusion in Early Childhood Intervention Services: Practice Guide. ECIA (NSW Chapter).

Centre for Community Child Health (CCCH). (2011). DEECD Early Childhood Intervention Reform Project: Revised Literature Review. Melbourne, Victoria: Department of Education and Early Childhood Development, viewed on 30 July 2015, <https://www.eduweb.vic. gov.au/edulibrary/public/earlychildhood/intervention/ecislitreview.pdf>.

Centre for Community Child Health (CCCH). (2004). Refocusing Community Based Services for Young Children and Their Families. Royal Children's Hospital, Melbourne. www.rch.org.au/ccch

Cerniauskaite, M., Quintas, R., Boldt, C., Raggi, A., Bickenbach, J., & Leonardi, M. (2011). Systematic literature review on ICF from 2001 to 2009: its use, implantation and operationalisation. Disability and Rehabilitation. 33 (4). 281-309.

Darragh, J. (2007). Universal design for early childhood education: Ensuring access and equity for all. Early Childhood Education Journal, 35 (2), 167-171.

Davies, S. (July, 2008). 'Team Around the Child at work in Australia' Interconnections Quarterly Journal 1, 2. London. www. icwhatsnew.com

Davies, S. (2007). Team Around the Child: Working together in early childhood intervention. Wagga, NSW: Kurrajong Early Intervention Service. http://www.kurrajongwaratah.org.au/Products.aspx

Davis, F.A., (2014). 'Promoting responsive parent/caregiver - child interactions during natural learning activities', CASEinPoint, vol.6, no.1, pp.1-13, viewed on 28 July 2015 <http://fipp.org/static/media/uploads/caseinpoint/caseinpoint_6-1.pdf>.

Dempsey, I., & Keen, D. (2008). A review of processes and outcomes in family-centered services for children with a disability. Topics in Early Childhood Special Education, vol.28, no.1, 42-52.

Dempsey, I., & Dunst, C. J. (2004). Help-giving styles and parent empowerment in families with a young child with a disability. Journal of Intellectual and Developmental Disability, vol.29, no.1, 40-51.

Department for Education and Child Development (DECD) (2014). Team Around the Child Strategy: Principles and Practice - Resource for Practitioners. Government of South Australia.

Department of Education and Early Childhood Development (DEECD). (2011). Victorian Early Years Learning and Development Framework: For all Children from Birth to Eight Years, viewed on 28 July 2015 <http://www.education.vic.gov.au/Documents/childhood/providers/edcare/veyldframework.pdf>.

Department of Human Services and Department of Education and Early Childhood Development (DHS &DEECD), (2012). Family-centred, person-centred practice: a guide for everyday practice and organisational change, State Government of Victoria, Melbourne.

Dew, A., De Bortoli, T., Brentnall' J. & Bundy A. (2014). Strengthening Supports for Children 0–8 years and their Families: A Literature Review, The University of Sydney, viewed on 25 March 2015, <http://www.adhc.nsw.gov.au/__data/assets/file/0003/297390/Strengthening_Supports_for_Children_0_-_8_years_and_their_Families_A_Literature_Review_PDF.pdf>

Dew, A., Bulkeley, K., Veitch, C., Bundy, A., Gallego, G., Lincoln, M., Brentnall, J. & Griffiths, S. (2013). 'Addressing the barriers to accessing therapy services in rural and remote areas,' Disability and rehabilitation vol.35, no.18, pp.1564-1570.

Dew, A., Veitch, C., Lincoln, M., Brentnall, J., Bulkeley, K., Gallego, G., Bundy, A. & Griffiths, S. (2012). 'The need for new models for delivery of therapy intervention to people with a disability in rural and remote areas of Australia', Journal of Intellectual and Developmental Disability, vol.37, no.1, pp.50-53.

Drennan, A., Wagner, T. and Rosenbaum, P. (2005). The 'Key Worker' Model of Service Delivery. Keeping Current #1-2005. Hamilton, Ontario: CanChild Centre for Disability Research.

Dunst, C. J. (2006). Parent-mediated everyday child learning opportunities: I. Foundations and opera-tionalization. CASEinPoint, 2 (2), 1-10. http://www.fippcase.org/caseinpoint/caseinpoint_vol2_no2.pdf

Dunst, C. (2010). Advances in the understanding of the characteristics and consequences of family-centred practices. Paper presented at the ECIA Professional Development Series, Melbourne.

Dunst, C.J., Raab, M., Trivette, C.M. & Swanson, J. (2010). Community-based everyday child learning opportunities. In R. A. McWilliam (Ed.). Working with Families of Young Children with Special Needs. New York: Guilford Press.

Dunst, C.J. and Swanson, J. (2006). Parent-mediated everyday child learning opportunities: II. Methods and procedures. CASEinPoint, 2 (11), 1-19. http://www.fippcase.org/caseinpoint/caseinpoint_vol2_no11.pdf

Dunst, C.J. & Trivette, C.M. (2009). Capacity-building family-systems intervention practices. Journal of Family Social Work, 12 (2), 119–143.

Dunst, C. J., & Trivette, C. M. (2008). 'Using research evidence to inform and evaluate early childhood intervention practices', Topics in Early Childhood Special Education, pp.1-13.

Dunst, C. J. (2007). 'Early intervention for infants and toddlers with developmental disabilities', in S. L. Odom, R. H. Horner, M. Snell, & J. Blacher (Eds.), Handbook of developmental disabilities, pp.161-180. New York, NY: Guilford Press.

Dunst, C., Trivette, C., & Hamby, D. (2007). Meta-analysis of family-centred helpgiving practices research. Mental Retardation and Developmental Disabilities, 13, 370-380.

Dunst, C. J., & Bruder, M. B. (2006). 'Early intervention service coordination models and service coordinator practices', Journal of early intervention, vol.28, no.3, pp.155-165.

Dunst, C.J., (2000). 'Revisiting "Rethinking Early Intervention"', Topics in Early Childhood Special Education, vol.20, no.2, pp.95-104.

Dunst, C. J., Trivette, C. M., & Deal, A. (1988). Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA: Brookline Books.

Early Childhood Intervention Australia (NSW Chapter). (2014). Early Intervention Best Practice discussion paper. Retrieved from http://www.ecia.org.au/documents/item/114.

ECIA and ECA (2012). Position on the inclusion of children with disability in early childhood education and care can be accessed at www.earlychildhoodaustralia.org.au and www.ecia.org.au.

Family and Community Services. (July 2015). Strengthening supports for children and families. 0 to 8 years. Now and into the future. University of Sydney. NSW Government.

Fordham, L., Gibson, F., & Bowes, J. (2012). Information and professional support: key factors in the provision of family☐centred early childhood intervention services. Child: care, health and development, vol.38, no.5, pp.647-653.

Forster, J.; Davies, S.; Luscombe, D. & Skeats, H. (2013). 'Key issues surrounding the inclusion of children with disability into ECEC settings.' Every Child. ECA publication.

Gavidia-Payne, S., Meddis, K., & Mahar, N. (2015). Exploring Child and Family Outcomes in a Community-based Early Childhood Intervention Program for Children with Disabilities in Australia. Journal of Intellectual and Developmental Disability. 40, 57-67.

DOI: 10.3109/13668250.2014.983056

Greco, V., Sloper, P., Webb, R. and Beecham, J. (2005). An Exploration of Different Models of Multi-Agency Partnerships in Key Worker Services for Disabled Children: Effectiveness and Costs. DfES Research Report RR265.London, UK: Department for Education and Skills

Green, B., McAllister, C., & Tarte, J. (2004).'The strengths-based practices inventory: A tool for measuring strengths-based service delivery in early childhood and family support programs', Families in Society: The Journal of Contemporary Social Services, vol.85, no.3, pp.326-334.

Guralnick, M. J. (2011). 'Why early intervention works: A systems perspective', Infants and young children, vol.24, no.1, pp6-28.

Hadders-Algra, M. (2011). 'Challenges and limitations in early intervention', Developmental Medicine and Child Neurology, vol.53, pp.52-55.

(HREOC) Australian anti-discrimination and disability discrimination legislation .Available at http://www.hreoc.gov.au/about/legislation/index.html and http://www.hreoc.gov.au/about/links/index.html#ad

Hughes-Scholes, C. H., Gatt, S. L., Davis, K., Mahar, N., & Gavidia-Payne, S. (2015). 'Preliminary Evaluation of the Implementation of a Routines-Based Early Childhood Intervention Model in Australia Practitioners' Perspectives', Topics in Early Childhood Special Education, 0271121415589546.

Jung, L. A. (2003). More is better: Maximising natural learning opportunities. Young Exceptional Children, 6 (3), 21-27.

Karaasian O. & Mahoney, G. (2015). Mediational analyses of the effects of responsive teaching on the developmental functioning of preschool children with disabilities. Journal of Early Intervention, 37 (4), 286-299.

King, G., Strachan, D., Tucker, M., Duwyn, B., Desserud, S. & Shillington, M. (2009). The application of a transdisciplinary model for early intervention services. Infants and Young Children, 22 (3), 211-223.

King, G., Tucker, M., Baldwin, P. & LaPorta, J. (2006). Bringing the Life Needs Model to life: Implementing a service delivery model for pediatric rehabilitation. Physical and Occupational Therapy in Pediatrics, 26 (1-2), 41 – 68.

King, G., Tucker, M., Baldwin, P., Lowry, K., LaPorta, J. and Martens, L. (2002). A life needs model of pediatric service delivery: Services to support community participation and quality of life for children and youth with disabilities. Physical and Occupational Therapy in Pediatrics, 22 (2), 53-77.

KPMG. (2014). Early childhood intervention - an overview of best practice, viewed on 27 July 2015 <http://www.communityservices.act.gov.au/__data/assets/pdf_file/0007/635695/Early-Intervention-Best-Practice.pdf>.

Law, M., Rosenbaum, P., King, G., King, S., Burke-Gaffney, J., Moning, J., Szkut, T., Kertoy, M., Pollock, N., Viscardis, L. and Teplicky, R. (2003). Family-centred Practice. CanChild FCS Sheets. Hamilton, Ontario, Canada: CanChild Centre for Childhood Disability Research, McMaster University.

Limbrick, P. (2001). The Team Around the Child: Multi-agency service coordination for children with complex needs and their families. Worcester, UK: Interconnections.

Limbrick, P. (2004). Early Support for Children with Complex Needs: Team Around the Child and the Multi-agency Keyworker. Worcester, UK: Interconnections.

Limbrick, P. (2005). Principles and Practice that Define the Team-Around-theChild (TAC) Approach and their Relationship to Accepted Good Practice. Working Paper – June 2005.

Limbrick, P. (2009). TAC for the 21st Century: Nine Essays on Team Around the Child. Clifford, Herefordshire, UK: Interconnections.

Lincoln, M., Gallego, G., Dew, A., Bulkeley, K., Veitch, C., Bundy, A., Brentnall, J., Chedid, R.J. & Griffiths, S. (2014). 'Recruitment and retention of allied health professionals in the disability sector in rural and remote New South Wales, Australia', Journal of Intellectual and Developmental Disability, vol.39, no.1, pp.86-97.

Lindsay, S., King, G., Klassen, A. F., Esses, V., & Stachel, M. (2012). 'Working with immigrant families raising a child with a disability: challenges and recommendations for healthcare and community service providers', Disability & Rehabilitation, vol.34, no.23, pp. 2007-2017.

Llewellyn, G., Bundy, A., Mayes, R., McConnell, D., Emerson, E. & Brentall, J. (2010). Development and psychometric properties of the family life Interview. Journal of Applied Research in Intellectual Disabilities, 23, 52-62.

Luscombe, D. (2010). Learning every day in every way. Building the capacity of the child, family, community and professionals. Keynote address at the National ECIA Conference, Canberra.

Luscombe, D. (2009). Team Around the Child: building the capacity of all. Intellectual DisabilityAustralasia. September 2009.

Madden, L. (2005). 'Families with specific needs - Talking with culturally and linguistically diverse families', in Salter, G., Johnston, C. & Lunn, H. Does this Child Need Help? Identification and Early Childhood Education, Early Childhood Intervention Australia.

Mahoney, G. & Perales, F. (2005). Relationship-focussed early intervention with children with pervasive developmental disorders and other disabilities: A comparative study. Developmental and Behavioral Paediatrics. Vol 26, 2, April 2005.

McWilliam, R. A. (2010a). Routines-based early intervention supporting young children and their families. Baltimore, MD: Paul H. Brookes.

McWilliam, R.A. (2010b). 'Support-based home visiting', in R. A. McWilliam (Ed.). Working with Families of Young Children with Special Needs. New York: Guilford Press.

Moore, T. G. (2013). Teamwork in early childhood intervention services: recommended practices. Research paper for the NDIS. Centre for Community Health.

Moore, T.G. (2012). 'Rethinking early childhood intervention services: Implications for policy and practice', Pauline McGregor Memorial Address presented at the 10th Biennial National Conference of Early Childhood Intervention Australia, and the 1st Asia-Pacific Early Childhood Intervention Conference, Perth, Western Australia, 9th August, viewed on 27 July 2015 <http://www.rch.org.au/uploadedfiles/main/content/ccch/profdev/ecia_national_conference_2012.pdf

National Medical and Health Research Council 2005, Cultural competency in health: a guide for policy, partnerships and participation, viewed November 2011, <www. nhmrc.gov.au/_files_nhmrc/ publications>.

National Professional Development Center on Inclusion (2011). Research synthesis points on practices that support inclusion. Chapel Hill, North Carolina: National Professional Development Center on Inclusion, FPG Child Development Institute, The University of North Carolina. http://npdci.fpg.unc.edu/sites/npdci.fpg.unc.edu/files/resources/NPDCI ResearchSynthesisPointsInclusivePractices-2011_0.pdf

National Disability Insurance Scheme. (2015). Proposal for a National Disability Insurance Scheme Quality and Safeguarding framework, Consultation Paper, viewed 4 August 2015 <https://engage.dss.gov.au/wp-content/uploads/2015/01/Proposal-for-an-NDIS-Quality-and-Safeguarding-framework-7.pdf>.

Odom, S.L., Buysse, V. and Soukakou, E. (2011). Inclusion for young children with disabilities: A quarter century of research perspectives. Journal of Early Intervention, 33 (4), 344-356. doi: 10.1177/1053815111430094

Sameroff, A. (Ed.) (2009). The Transactional Model of Development: How Children and Contexts Shape Each Other. Washington, DC: American Psychological Association

Sandall, S.R. and Schwartz, I.S. (2008). Building Blocks for Teaching Preschoolers with Special Needs (2nd Ed.). Baltimore, Maryland: Paul H. Brookes.

Shelden, M.L. and Rush, D.D. (2013). The Early Intervention Teaming Handbook: The Primary Service Provider Approach. Baltimore, Maryland: Paul H. Brookes.

Shelden, M.L. & Rush, D.D. (2010). 'A primary-coach approach to teaming and supporting families in early childhood intervention', in R. A. McWilliam (Ed.). Working with Families of Young Children with Special Needs. New York: Guilford Press.

Shonkoff, J.P. (2010). Building a new bio-developmental framework to guide the future of early childhood policy. Child Development, 81 (1), 357-367.

Shonkoff, J. & Phillips, D. (Eds.) (2000). From Neurons to Neighborhoods: The Science of Early Childhood Development, NRCIM. Washington, DC: National Academy Press.

Sroufe, L.A. (2009). The concept of development in developmental psychopathology. Child Development Perspectives, 3 (3), 178-183.

UN Convention on the Rights of Persons with Disabilities. Available at http://www.hreoc.gov.au/disability_rights/convention.htm

UNESCO Salamanca Statement (1994). Available at http://www.unesco.org/education/pdf/SALAMA_E.PDF

UNICEF (1990). Convention on the rights of the child. Available at www.unicef.org/crc/crc.htm

Workgroup on Principles and Practices in Natural Environments (WPPNE), (2008). Seven key principles: Looks like/doesn't look like, OSEP TA Community of Practice: Part C Settings, viewed on 31 July 2015 <http://www.ndis.gov.au/sites/default/files/documents/seven_key_principles.pdf>.

Woodruff, G. and McGonigel, M.J. (1988). Early intervention team approaches: The transdisciplinary model. In J.B. Jordan et al. (Eds.), Early Childhood Special Education: Birth to Three. Reston, Virginia: Council for Exceptional Children. Workgroup

Worthman, C.M., Plotsky, P.M., Schechter, D.S. & Cummings, C.A. (2010). Formative experiences: The interaction of caregiving, culture, and developmental psychobiology. Cambridge, UK: Cambridge University Press.

Ziviani, J., Feeney, R., Rodger, S., & Watter, P. (2010). 'Systematic review of early intervention programmes for children from birth to nine years who have a physical disability', Australian occupational therapy journal, vol.57, no.4, pp.210-223.