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More IS Better:

Maximizing Natural Learning Opportunities

Wyatt was just six weeks old when he started early intervention. Other than recovering from heart surgery, he was doing great. Down's syndrome certainly didn't stop Wyatt from charming everyone around

him with his great looks and personality. Wyatt surprised everyone with his outstanding developmental progress.

For two years Wyatt received early intervention services in a segregated, center-based early intervention program, and his parents could not have been happier. He received intervention designed and implemented by trained early interventionists three days per week and all day long. In response to legislation to serve children in their natural environments, Wyatt's program is about to change. The early inter-

ventionists will be visiting once each week to consult with his parents and childcare providers. Stacy and Carey, like many parents, are concerned. How can Wyatt possibly get what he needs at home or in childcare with only weekly visits

from the early intervention team? How can that possibly be as good as trained early intervention teachers and therapists working with him every day?

Legal and Practical Changes

With the 1997 revision of the Individuals with Disabilities Education Act (IDEA), there has been an increased emphasis on providing early intervention services within natural environments. IDEA defines natural environments as "settings that are natural or normal for the child's age peers who have no disability" (Sec. 303.18). The Code of Federal Regulations elaborated on this definition calling natural environments "... home and community settings in which children without disabilities participate" (Sec. 303.12[b], 1997; Sec. 672[2][G], 1991).

For many early intervention programs providing services prior to 1997, this new emphasis meant a major shift in the way they operated. Some early intervention programs have existed since the mid-1970s, more than 15 years before early intervention was added to the legislation. Many programs provided early intervention services





to qualifying infants and toddlers in centers exclusively for children with developmental delays and disabilities, where there was no opportunity for interaction with typically developing peers. A large number of these programs continued their segregated-intervention model well into the 1990s. Some states had segregated, center-based services as the predominant model as recently as 1998 (OSEP, 2002). Administrators of such programs faced the challenge of completely transforming their programs in order to comply with the legislative call for services in natural environments.

How, Not Just Where

In response to the increased emphasis on natural environments, many professionals have focused on location or *where* the early interventionist works with the child, thus meeting the letter of the law while neglecting the spirit of the law (Jung, in press). Although a natural location, such as a home or childcare center, does indeed meet the literal interpretation of the law, location alone does not meet the intent of the law. By emphasizing services in natural environments, the authors of the Amendments to IDEA sought much more than a change in location of service delivery (NECTAS, 2000; OSEP, 2002). The intent was to change the focus of intervention from working directly with children to supporting caregivers to enhance the development of the children in their care (McWilliam, 1995; McWilliam & Strain, 1993;

NASDSE, 1999). One rationale for this focus shift was that families and caregivers are their children's first teachers, and even if early interventionists visited children every day, families and other caregivers still have more opportunities to impact their children's development (Bronfenbrenner, 1979).

Unnatural in a Natural Location

Merely moving the location of services from segregated to inclusive settings does not guarantee support to the family or caregivers (McWilliam & Strain, 1993). In fact, services that are provided in a natural location can still be delivered in an unnatural manner. For example, a speech and language pathologist could travel to an infant's home and work directly with that infant as if in a clinic while the family or caregiver is in another room. A physical therapist could travel to a childcare center and pull a toddler to another room to provide range-of-motion exercises. Although these locations are the natural environments for these children, clearly this type of service delivery ignores the primary purpose of the change in legislation (Turnbull, Blue-Banning, Turbiville, & Park, 1999). Because of the relatively insignificant time that early intervention professionals spend with each child, it is more important to go beyond a focus on where the visit occurs to thinking about what occurs during the visit.

Two important strategies interventionists can share with families

and caregivers are how to: (1) Maximize natural learning opportunities using everyday activities that children experience (Dunst, Bruder, Trivette, Raab, & McLean, 2001); and (2) Embed intervention in daily routines-incorporating a designed intervention into a typical activity or routine (Cripe & Venn, 1997).

Who Is Intervening Anyway?

Many early interventionists have concerns that they can no longer see children two to three times per week. But wait a minute; why limit intervention to two or three times per week? After all, more is better, right? Oftentimes, the most efficient route to getting more intervention, however, is not through early interventionists' visits. Children have natural learning opportunities throughout their day, whether learning is planned or unplanned (Dunst, Bruder, Trivette, Raab, & McLean, 2001). Trips to the store, a walk to the mailbox, and washing dishes all provide natural learning opportunities. These activities provide many brief teachable moments throughout the day (Cripe & Venn, 1997). Parents intervene in their children's development every day. They have infinitely more opportunities to enhance their child's development than a professional who visits weekly. Families do many wonderful things with their children every day to teach them without ever being told to do so by an early interventionist. These daily



interactions between families and children have a much greater impact on child progress than do early intervention sessions (Dunst, Bruder, Trivette, Raab, & McLean, 2001; Hanft & Pilkington, 2000; McWilliam, 2000).

Making the Most of Your Time

With a change in location comes a need for other changes. In center-based programs, the therapists and developmental specialists were the interventionists. Children participated in activities that targeted their developmental goals. If in a community-based model the early interventionists are still thought of as the people who *implement* intervention, then the use of intervention strategies will likely be limited to therapy or instruction time during the home or childcare visit. For example, if a father wants his two-year-old daughter to learn to use new words to tell others what she wants, early interventionists would be limiting intervention if they focused on speech therapy time and did not recognize the father's everyday opportunities to implement intervention strategies. This is not to say that efforts should focus on turning the father into a teacher or therapist, but rather early interventionists could give him strategies to recognize and use natural learning opportunities by enhancing the many wonderful things he already does with his daughter. Similarly, instead of using a childcare visit to provide direct therapy, a physical therapist could give ideas for a positioning

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technique that a caregiver could embed into Art and Circle Time.

Many people think of consultation as providing expert or professional advice. This commonly understood premise, however, does not say who is consulting with whom in early intervention. Some early interventionists have interpreted a consultative model to mean that professionals consult with one another. For example, a speech and language pathologist would give strategies to a developmental interventionist who could then carry out the speech therapy. Although sharing information between the specialists is important, this level of consultation may not be enough to maximize home and childcare visits. This type of consultation alone could still limit intervention opportunities. File and Kontos (1992) provide a clearer picture of consultation in natural environments. They describe consultation as a triadic helping process in which the consultant (early interventionist) provides intervention to the child through the child's family or caregiver. In other words, while it is important for early interventionists to collaborate and share what each is doing, the consultation should focus on sharing information and supporting the family and childcare providers.

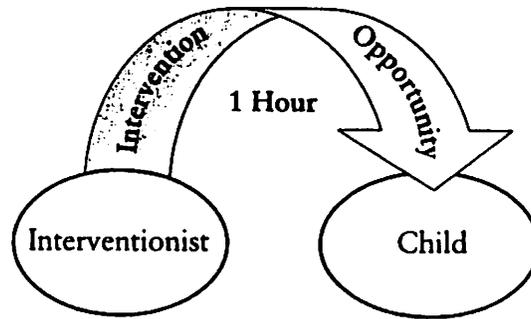


Figure 1:
Weekly Intervention Opportunities.

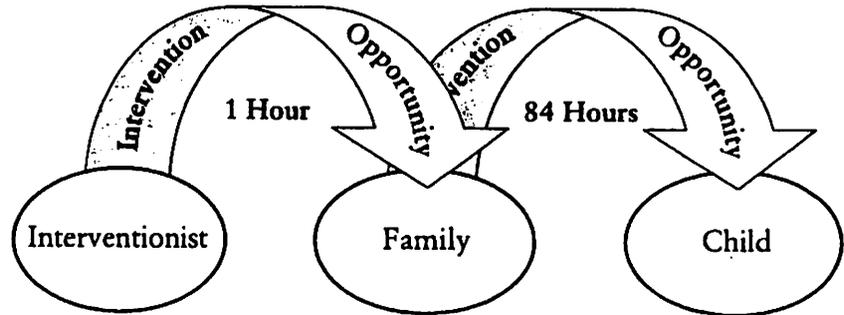
By providing strategies to caregivers that allow them to maximize natural learning opportunities in their daily routines and activities, the child has multiple opportunities for intervention across the day, every day, and in contexts that are immediately meaningful to the child and family. Let's take, for example, a toddler who is awake 12 hours per day and receives a therapy visit once per week for one hour. If the professional provides only direct therapy for the child, that child has one hour of opportunity for intervention each week. This one-hour opportunity is probably not embedded into a natural routine. If that professional instead wisely uses the hour to provide strategies to the family or other caregivers, the child now has significantly more opportunities for intervention each week. Figure 1 provides a graphic representation of this concept of increasing opportunities to enhance the probability of positive impact.

Certainly, no caregiver should be consumed with thinking about developmental intervention during every waking moment; that would be completely unnatural. The point is that the number of *opportunities* can be increased using this model. Furthermore, instead of intruding into a family's home three to four times each week—making their lives anything but typical—early interventionists can support the families' ability to embed intervention into their everyday activities and routines by recognizing and using natural learning opportunities.

DIRECT SERVICES MODEL



CONSULTATIVE MODEL



Deciding Frequency

How significant is the child's delay or disability? Is this a caregiver who has the resources to follow through with intervention? In the past, these are questions early interventionists may have used for assistance in deciding on the frequency of early intervention visits. At first glance, the logical course may have seemed to be providing more services more frequently to children with more significant disabilities. However, since the goal of early intervention should be to support the families' ability to enhance their child's

development, visiting too often can send a disempowering message. That is, early interventionists through frequent visits may communicate to families that they are not competent enough to make a change in their children's development and need experts implementing the intervention. On the other hand, early interventionists need to provide adequate support to families and childcare providers. Finding a balance between enough but not too much may be difficult for professionals. Changes in the content of our initial questions may be helpful. In Table 1, we

Table 1:
Questions to Decide Frequency.

Old Questions	New Questions
1. How significant is the child's delay or disability?	1. How often will the child's intervention likely need to be changed?
2. Does this family have the resources to follow through?	2. How often does the family need support to be comfortable in using intervention strategies?

provide a comparison of the "old questions" and the "new questions" to consider when coming to a decision about the appropriate amount and frequency of visits. Let's look at the two new questions to better understand the decision process.

How often will strategies need to be changed?

By asking how often the strategies will likely need to be changed, professionals will probably arrive at a very different frequency than by asking the old question about severity. A child with more significant disabilities may require intervention in some areas that largely stay the same for months at a time. For example, a child with multiple, severe disabilities may need positioning and movement strategies designed by a physical therapist. These strategies will need modifications infrequently, certainly not weekly and maybe not even monthly. Visiting the child three times each week to assess the caregivers' ability to

continue with a strategy you gave them could be intrusive and insulting of their ability. One physical therapist in a training recently remarked, "I go every week because the family wants me to come, but each time I pretty much say, 'Good job; keep it up.'" Instead, a single member of the team could visit the family every week or so to ensure the family is receiving all supports they need, and the other five team members can stop tripping over each other every week.

What level of support does the family need?

Instead of assuming that some families or caregivers will not follow through with strategies, early interventionists should consider what supports a family or caregiver will need to be able to follow through. A family who has a daughter with cerebral palsy, for example, may be afraid of hurting their child as they position and work with her. This family may need very frequent visits for a

couple of weeks until the family is comfortable with what they are doing.

Frequent visiting can be counterproductive. Frequent visits could lead to exactly what early interventionists are trying to guard against—lack of follow-through. Visiting too frequently can actually be damaging to the family's feeling of support, and thus be ultimately damaging to child outcomes (Dunst, 1999). Very frequent visiting can imply that the family is not perceived to be competent enough to enhance the child's development. If interventionists focus on direct teaching activities or therapy during the visit, the family may infer that instruction time, separate from their normal daily routine, is necessary for the child to learn. Because of too-frequent visiting, families or childcare providers may grow to believe that only early interventionists can make changes in the development of children with delays or disabilities. If families believe they have no power to enhance the development of their child with disabilities, why would they follow through? Furthermore, if they feel interventionists have the power to change their child's development, of course they are going to want them to come as much as possible.

Conclusion

Wyatt had a wonderful occupational therapist who gave his parents strategies they could embed into eating, bath, and play times. All activities that the family had shared were parts of their regular



routines. His developmental interventionist gave Stacy and Carey ideas to maximize natural learning opportunities. Consequently, Wyatt received intervention many times each day. The early interventionists who worked with Wyatt's family would argue that although these strategies were helpful, the majority of intervention Wyatt received was not directed by the interventionists, but instead was the natural interaction between Stacy and Carey and their little boy. In Wyatt's situation, had the therapist gone to his home or childcare center and provided direct therapy five times each week with no consultation, many opportunities for intervention would have been lost.

Families have been saying it all along—more is better. They are going to demand the most they can get. Any caring family is going to want the best they can get for their child. Early interventionists need to understand and be able to explain that sometimes more is better, but oftentimes the most efficient way to get more is to support the family's ability to maximize natural learning opportunities and embed intervention into their own activities and routines.

Note

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