



Teamwork in early childhood intervention services: recommended practices

Forms of teamwork

In the early childhood intervention sector, several different forms of teamwork have been identified:

Multidisciplinary teamwork: This model involves a group of professionals working independently with a family and having minimal interaction with one another. Each specialist conducts their own assessment, develops discipline-specific goals, and works directly with the child to remediate weaknesses identified in their assessments.

The advantage of this model is that it maximises the specialist skills of the different professional disciplines. However, there are a number of disadvantages that arise from the lack of co-ordination between what the different professionals are doing. There is a high risk of professionals providing contradictory advice to families, and of making cumulative demands upon families that are both unrealistic and highly stressful.

Interdisciplinary teamwork: This model involves a team of professionals that may conduct their own assessments and develop discipline-specific goals, but meet regularly to coordinate service planning. Actual service delivery is still done by the professionals separately, but as part of an overall plan.

This form of teamwork reduces some of the potential for providing families with conflicting advice and overloading them with demands on their time, but does not completely eliminate these problems. There is evidence that families find the constant rotation of visits from different professionals confusing and

stressful. There is also evidence that having multiple professionals from different disciplines providing decontextualised, child-focused and deficit-based interventions is not the most effective way of delivering support to families.

Transdisciplinary teamwork: This model involves a team of professionals who work collaboratively, and share the responsibilities of evaluating, planning and implementing services to children and their families. Families are valued members of the team, and are involved in all aspects of intervention. One professional is chosen as the primary service provider for the family, and acts as the conduit for the expertise of the team. The full team remains involved, and the primary provider reports back to the team constantly.

A particular feature of this model is what is known as role transfer or role release: the primary provider uses some direct intervention strategies from outside their discipline with supervision and support from relevant team members. This sharing of roles across disciplinary boundaries is the most challenging aspect of transdisciplinary practice and the most controversial among practitioners who have been trained in traditional forms of service delivery.

The main reason for adopting this approach is that there is good evidence that parents prefer and do better with a single case worker. The more health or development problems a child has, the more services they receive and the more service locations they have to access. Under these circumstances,

services are less family-centred. What parents want is a single point of contact with services and an effective, trusted person to support them to get what they need.

This is one of the main reasons why transdisciplinary practice is regarded as best practice in early intervention services. The advantages of this way of working are that it greatly simplifies family relationships with the specialist team, ensures family receives coordinated advice, involves the family in all decisions, enables the family to manage the demands upon their time, and reduces family stress. There is good evidence that this results in greater family satisfaction with services, more family-centred service delivery, and better outcomes for children and families.

However, it is not an easy model to implement. It requires a high degree of trust between the professionals involved, and therefore works best with a stable team of experienced practitioners. New practitioners must first develop competence in their own skill areas, and then expand their knowledge to include some basic interventions from outside their own discipline. Since stable teams of experienced practitioners are not always available, it may not be feasible to expect or mandate transdisciplinary practice in every case.

These three models of teamwork were originally conceptualised in the context of a model of service delivery that was principally focused on practitioner-child interventions, with limited attention to the adults in children's lives and the quality of children's everyday environments. This approach has proved to be moderately effective at best, and it is now recognised that early childhood intervention should be focusing much more on supporting caregivers in providing optimal experiences for the children in the course of their everyday lives.

A teamwork model that fits better with this reconceptualisation of early childhood intervention is the primary service provider or key worker model.

Primary service provider / key worker model: This involves a team of professionals from different disciplines that meets regularly and that nominates one member as the primary service provider or key worker. With support from the other team members, the primary service provider works in partnership

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with parents and other caregivers to support and strengthen their capacity to provide children with opportunities and experiences that will promote the children's learning, development and participation in everyday activities.

The primary service provider's first job is to build a supportive partnership-based relationship with families and other caregivers. The focus is on the child in the context of the family and community, rather than child in isolation. The primary service provider seeks to become an expert on the family's circumstances, routines, interests and values as a basis for helping the family find ways of promoting the development of the child's competencies in the course of everyday activities.

Another main focus is building the confidence and competence of parents and other caregivers in promoting the child's development and participation. The aim is not for the primary care provider to work directly with the child to improve functioning, but to build the capacity of those who care for the child to do so.

The primary service provider also acts as the principal resource and single point of contact for a family, providing them with support, resources and information tailored to meet their individual needs, and helping them access and coordinate the services they need.

As with the transdisciplinary model, the rationale for this model is based on the evidence that provision of a primary service provider is preferred by parents and results in better outcomes for children and families. Although sharing many similarities with the transdisciplinary teamwork model, the primary service provider model is seen as an enhancement of this model, and therefore differs from the transdisciplinary model in a couple of important ways.

First, the focus of support is broader than in transdisciplinary teamwork as it has usually been described. In the primary care provider model, the focus is on the environments in which children spend their time, and how these can be enhanced to promote the child's development and participation. This is in contrast to a narrower focus on child functioning independent of context.

Second, the primary service provider model does not require role transfer or role release for the purpose of implementing deficit-based or skill-focused interventions that are typically carried out by other disciplines. Where such intervention is required, the relevant team members should be involved. However, while this narrow form of role transfer is not required, the primary care provider still acts as the conduit for the expertise of the whole team in most situations, and uses transdisciplinary practices when doing so.

Using a primary care provider approach to teamwork does not mean that the other team members never have any direct contact with the child and family. They may be involved in a number of ways, including joint visits for consultation or assessment purposes. The other team members are also responsible for providing an ongoing oversight of their specialty area in regard to the particular child, and for coaching the primary care provider in strategies that are relevant to the child and family.

Conclusions

The theme that emerges most consistently from research and evolving practice is how important it is for families to have a single trusted team member who helps them access and coordinate the external resources that the family needs, and build their own internal resources to meet child and family needs. Of the teamwork models considered above, the primary service provider / key worker model seems best suited to this role.

Given the current sensitivities of the early childhood intervention field regarding transdisciplinary practice, adopting this model would be particularly advantageous. As there also appears to be some sensitivities among (local) practitioners regarding the term 'key worker', then the term 'primary service provider' to describe this role might be preferred.

References

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

Briggs, M.H. (1997). **Building Early Intervention Teams: Working Together for**

Children and Families: Gaithersburg, Maryland: Aspen Publishers.

Bruder, M.B. (2010). Coordinating services with families. In R. A. McWilliam (Ed.) (2010). **Working with Families of Young Children with Special Needs**. New York: Guilford Press.

Centre for Community Child Health (2011). [DEECD Early Childhood Intervention Reform Project: Revised Literature Review](#). Melbourne, Victoria: Department of Education and Early Childhood Development.

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.

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.

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

Moore, T.G. (2012). [Rethinking early childhood intervention services: Implications for policy and practice](#). Invited *Pauline McGregor Memorial Address* to the 10th Biennial National Early Childhood Intervention Australia (ECIA) Conference and 1st Asia-Pacific Early Childhood Intervention Conference 2012, 9th August, Perth, Western Australia.

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

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 on Principles and Practices in Natural Environments (2008). [Agreed upon mission and key principles for providing early intervention services in natural environments](#).

Chapel Hill, North Carolina: National Early Childhood Technical Assistance Centre, Office of Special Education Programs, US Department of Education.

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