

# **Speech-Language Pathologists in Early Childhood Intervention**

**Working With Infants, Toddlers,  
Families, and Other Care Providers**



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Families, and Other Care Providers**

*Kathleen D. Ross, MS, CCC-SLP*





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## **Section I. General Information About Early Childhood Intervention 1**

Within this section is a general overview of the history and rationale for early childhood intervention, including the Individuals with Disabilities Education Act (IDEA) Part C program, Early Head Start, and a brief description of the need for speech-language pathologists (SLPs) in early intervention. The process within early intervention from the receipt of referrals to evaluation (to determine eligibility) to the development of the Individualized Family Service Plan is discussed. Emphasizing the importance of developing respectful interactions with our culturally and linguistically diverse families and children precedes the Part C philosophies of delivering services within natural environments during daily routines. The final two chapters in this section relate to creating partnerships with parents, caregivers, families, and professional colleagues to deliver collaborative services.

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# Foreword

Early intervention is an investment in our future as many of the children we nurture and support in their first three years of life will become our future leaders and health care providers. For me, this is a critical investment in knowledge and resources. I am especially pleased to know that we have authors like Kathleen D. Ross who recognize the importance of knowledge investment in speech-language pathologists who have a critical role in the evaluation, assessment, and intervention for young children with or at risk for communication disorders. *Speech-Language Pathologists in Early Childhood Intervention: Working With Infants, Toddlers, Families, and Other Care Providers* is a powerful tool to educate our speech-language pathologists on the value they add to a team of providers who will create learning success for our youngest population.

Ross provides a logical sequence for supporting learning that can be immediately applied to early intervention practice. She divides the text into three sections: (1) exploring what early intervention is, the important steps to referral and identification, and collaboration with parents and teams (the first six chapters); (2) explaining assessment tools, key intervention strategies, and typical caseloads (the next five chapters); and (3) explaining the essence of why early intervention matters (the final four chapters).

In her first chapter, Ross defines early intervention and the importance of early childhood programs, including the early work and success of Head Start, to the role of lead agencies within each state to meet early intervention needs. Her inclusion of

a child and family story makes the experience of early intervention real and uses research to confirm its importance. Tables are included that highlight the lead agencies with web-links and an examination of the economics of early intervention over time (Hyson & Biggar Tomlinson, 2014). Ross succeeds in making a case for early intervention and those child outcomes that should be our priority.

In Chapter 2, Ross clearly outlines the comprehensive process in Part C from referral and screening to guiding the clinician through eligibility using the assessment information gathered, to the development of individual family service plans and identification of early childhood outcomes. Ross outlines the regulations for creating a plan of action and provides a valuable report template and example as well as a decision tree for rating service needs. She presents her content in the context of actual case scenarios so the reader and learner are armed with the information necessary to make good decisions about referral and best practice approaches to assessment.

A focus on cultural and linguistic diversity in support of young children representing a variety of cultural differences is comprehensively examined in Chapter 3. The extent of the discussion and support in the literature provided is impressive as Ross explores the role of interpreters, translators, and cultural mediators or cultural brokers in the service provision process. Again, the use of family and child stories and comparisons across cultural contexts (e.g., deaf, international adoption, refugees, LGBT [lesbian, gay, bisexual,

transgender], dual language learners, etc.) is a powerful strategy to enhance the reader's knowledge of the level of awareness that is critical to support our growing diversity. Several figures that help tell the story of the role of culture in early intervention are included.

Chapter 4 describes the home visit and other natural environments—a cornerstone for effective early intervention practice. Ross offers insights from several cases, highlighting what makes for a successful versus an unsuccessful home visit. She offers great suggestions for home visit preparation and activities likely to support language, communication, and social interaction in the context of the family's routines. She includes a discussion of responses to unexpected events and holding paramount the principles of family-centered care. This discussion is followed by Chapters 5 and 6 that continue the emphasis on working “with” families and collaborating with other key care providers. She recognizes the importance of educating and coaching families using adult learning strategies that they can easily understand and apply, and focusing on team collaboration when providing services to this young population. Through several case scenarios, Ross outlines the likely roles and responsibilities of the speech-language pathologist in carrying out an early intervention program and the need to understand the roles of other team members and how to collaborate with them to make a difference for young children and their families. Ross describes the typical toddler day, whether at home or in child care, and the number of opportunities to engage.

Chapters 7 and 8 focus on the assessment process and the determination of eligibility for services. These chapters highlight both formal and informal tools used to assess all the key domains of

learning in young children (e.g., adaptive, cognitive, communication, motor, social) and describe the advantages and disadvantages of each tool, including those domain assessments that do a more or less comprehensive job of assessing a young child's communication. Ross also examines more traditional language assessment tools for young children likely to be used by speech-language pathologists, outlining how that information fits with the larger description of the child's functioning. She outlines available, highly used, and respected tools to facilitate the assessment process, while emphasizing the value added of informal observation and applying what we know about typical child development to our decision making across domains of learning. She explains the importance of speech-language pathologists understanding their role and responsibilities to provide the best possible screening, assessment, and ongoing support for dual language learners (DLLs) or English language learners and their families. Several case examples are offered to walk the reader through interpretation of the assessment process and an excellent language sample analysis following Brown's stages of language development is presented in an appendix.

Chapter 9 introduces treatment approaches to support infants, toddlers, young children, and their families. Ross does an effective job of revisiting assessment tools like the *Hawaii Early Learning Profile* (HELP; Warshaw, 1992), the *Assessment Evaluation Program System* (AEPS; Bricker & Waddell, 2002), and the *Transdisciplinary Play-Based Assessment-2* (TPBA-2; Linder, 2008a)/*Intervention-2* (TBPI-2; Linder, 2008b) for infants and children—guiding the clinician to use the curriculum development tools developed from these domain assessments. She also highlights interventions designed to sup-

port the communication of young children through parent training (e.g., *It Takes Two to Talk*<sup>®</sup> and *More Than Words*<sup>®</sup>, Hanen Centre, 2011) and other naturalistic interventions such as pivotal response treatment (Koegel & Koegel, 2006), Floortime (Greenspan & Wieder, 2001), and milieu teaching (Curiel & Sainato, 2016).

The last two chapters in this section (Chapters 10 and 11) examine the needs of medically complex children, children with hearing loss, and those with other neurodevelopmental disabilities such as autism and Down syndrome. Ross describes the complexity of issues that face the development of language and communication in these populations and provides resources to understand the best ways to support their individual and collective needs.

In the final section of the text, Ross includes four chapters designed to increase the reader's understanding of why early intervention and a process to bridge programs to more formal education are so critical. Ross emphasizes our need to support the whole child and the child's family, prepare the family for transition to early childhood programs, help the family navigate the state regulations, and ensure receiving programs understand the importance of developmentally appropriate practice. In her discussion of the transition process, Ross offers examples of effective transition plans and what supports success. She capitalizes on the role of play and literacy in the ongoing devel-

opment of young children and outlines the National Association for the Education of Young Children's (NAEYC; Bredekamp & Copple, 2009) principles of development and learning that will be crucial to a young child's future success. Ross reviews the early learning guidelines of several states and makes connections to the common core standards. The final chapter seeks to present a process for ensuring our early intervention population has a healthy and productive future as we advocate for their needs and work to enhance policies that will ensure that future. Ross thoughtfully outlines the characteristics needed for effective providers, explains the value of being intentional in the modeling and coaching we provide, and ends with key take-away points that should influence the practice of not only speech-language pathologists, but families, care providers, and all members of the team who support our youngest children.

Kathleen Ross does an exemplary job providing a meaningful text that creates a true pathway for investing in the principles and activities of early intervention that can lead to best practice and positive outcomes for our youngest population. We have a responsibility to be intentional about what we do and how we do it as speech-language pathologists, and Ross' text gives us the tools to realize our intention to make a real difference in the care and support of infants, toddlers, and their families.

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# Preface

*True teaching cannot be learned from text-books any more than a surgeon can acquire his skill by reading about surgery.*

—Helen Keller Letter to Kathern Gruber, 11/1/1955. AFB, 2017

Why open a textbook with a quote that seems to downplay the importance of textbooks? Because though texts, research, and theory are crucial to our thinking, learning, and knowledge base, one's practical experience is just as imperative. Practical opportunities allow us to take the theory learned from textbooks, apply that theory to daily life, and see it in action. It is seeing knowledge grow from a different perspective that allows for contemplation and problem solving. I fully thank the researchers I work alongside of at the university level, learning of their latest findings, and being able to use their results in practice with children, but I'm just as thankful to work alongside practitioners in the field. As therapists, it is critical to have both theory and practice. As Keller said, I would not want a neurosurgeon performing surgery on my brain with only textbook knowledge.

I specifically chose this quote from Helen Keller because she is the reason I am a speech-language pathologist. From an early age, I determined that I wanted to work with preschool-age children who were faced with disabling situations, and I felt that losing sight and/or hearing would be one of the most challenging. All children should be able to access the world around them. Early intervention creates strong foundations with the philosophy of coaching parents to facilitate their child's development. Providing parents and caregivers the tools to best

support their children daily in their most comfortable environments empowers the family and, undoubtedly, is best practice.

The text's title specifies speech-language pathologists (SLPs) working in early intervention, but the information presented can easily pertain to early interventionists (EIs) in general, including occupational therapists (OTs) and physical therapists (PTs). The intended audience is graduate students and/or practicing SLPs considering work with infants and toddlers. To provide equal accessibility for all, most speech and language terms readily understood by SLPs are explained in order that EIs will have full comprehension as well. This text can also be considered for another audience—early interventionists who wish to understand what the SLP's role is in early intervention. Speech-language pathologists often advocate for our roles in different settings, informing others of the specifics of our work on the team. Discussing explicitly the unique areas of academic training and skills offered by each team member's respective field (e.g., OT, PT), could yield fruitful cross-training that would benefit both service providers and recipients of the services. Thus, using this text as a resource in this manner seems appropriate as well.

*Speech-Language Pathologists in Early Childhood Intervention: Working With Infants, Toddlers, Families, and Other Care Providers* was written with practicality in mind. Readers can explore areas for which

they want more information or use this as a tool and guide for immediate questions about an early interventionist's daily practice. It can also be a resource for handouts and information to share with parents, families, and staff for in-service trainings.

By providing the scenarios, targeted points are illustrated to better reflect the research, and vice versa. It is hoped that the scenarios validate or resemble situations the reader may have experienced. The situations might challenge expectations and thinking by having the reader step outside of his or her own lifestyle comforts to evoke emotional responses and deeper self-reflection on his or her own values. From this perspective, when working on an early intervention team, members can discuss how best to approach a family with respect, with gratitude for allowing us into their homes and lives, and ultimately, to move forward in an unbiased manner to support a child's development within the child's family.

In early intervention, there is evident bidirectionality—teaching others (adults and children), while at the same time learning (from families, other service providers, and even the children). Watching development happen right before our eyes, creating the “aha” moments from both the children and the adults—is rewarding. Witnessing graduate students and colleagues recognize when aspects of child developmental theories unfold before their eyes is inspiring. The moments when others internalize information garnered through text or practical experience are exciting. Observing children and adults able to do something that previously was unmanageable or an inability is remarkable. Sharing a moment with a parent or caregiver, while we observe their child make an inroad of communication with a

peer is well worth any waiting that might have occurred up to that point.

The format of *Speech-Language Pathologists in Early Childhood Intervention: Working With Infants, Toddlers, Families, and Other Care Providers* is distributed within three sections. The what, where, who, how, and why of the Individuals with Disabilities Education Act's (IDEA's) Part C early intervention services, especially pertaining to SLPs, are detailed in the first six chapters housed in Section I: General Information About Early Intervention. This section explores the general philosophy and process of Part C early intervention with parents, caregivers, and service providers being the main supports for eligible children within daily routines in natural environments. “Working Within Our Culturally and Linguistically Diverse World” is purposefully placed as the third chapter, before three chapters detailing visiting natural environments, and collaborating with families, caregivers, and colleagues. The rationale behind this foremost placement of the cultural and linguistic diversity information is simply because we need to know whom we will visit before initial contacts are made.

The middle portion of this text, Section II: Communication Assessment, Intervention, and Caseload, is perhaps the bulk of information. This resource-full section provides descriptions of formal and informal assessment tools, evidence-based intervention curricula and strategies, and typical caseload considerations that an SLP encounters in early intervention.

In the final Section III: The Essence of Early Intervention—Why EI Matters, further details of the philosophy and process of Part C are presented. For example, in this section, readers will learn the importance and how-tos of working holistically,

following state early childhood guidelines, and transitioning the child to preschool opportunities. This section concludes with the importance of advocating for our youngest citizens and their families to be able to access a program that can guide and support them to better footing in society.

Some general comments for ease of reading throughout the text include the following:

- Gender terms for both children and adults fluctuate to avoid the awkward representation of s/he or he/she, etc.
- The terms *parents* and *caregivers* are used interchangeably and considered a child's daily primary care provider.
- *Early interventionist* is a general term labeling those who work in early intervention (including SLPs); at times, it is used to represent a

general service provider (similar to the school-age special educator).

- Early childhood intervention is used interchangeably with early intervention (explained in Chapter 1).
- Though I chose to include many websites as resources (including government websites), I realize this is a rapidly changing world, so it is hoped enough information is presented to guide to new addresses.

## Reference

American Foundation for the Blind (AFB). (2017). Helen Keller Quotations. *Helen Keller Letter to Kathern Gruber, 11/1/1955*. Retrieved from <http://www.afb.org/info/about-us/helen-keller/quotes/125>

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I thank the folks in the many Vermont programs with whom I have shared countless children, families, and teachable moments—all of which have molded me into the professional I am. Thank you for the serious conversations, brainstorming, problem solving, and plentiful chuckles. I do not know what I would have done over these years without each of you by my side, guiding to help make better outcomes for the children and families with whom we worked. We never solved the problems of the world, but we certainly tried to make changes locally.

I am forever indebted to the children, families, and child cares with whom I have worked. I cherish strong memories of joys we shared, of challenges we worked through, and of giggles over cute little moments with children. I learned so much from each and every one of you. Thank you for accepting me into your homes, child cares, and lives.

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Kalie Koscielak, you have been kind, reassuring, patient, informative, and respectful, always responding and checking in a timely fashion. And, thank you to Plural Publishing for accepting this project that advocates for well-qualified personnel to support our youngest citizens to create firm grounding for their lives.

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*I dedicate this book to my daughters, Sasha and Alena, who have taught me so much about development, parenting and life, and how to be resilient through trying times. And, to my husband, Larry, for whom this project would not have been possible. Your encouragement and confidence in me; your insightful, unbiased comments on the drafts; and your companionship have kept me moving forward on a positive path to my passions.*



# SECTION

# I

## **General Information About Early Childhood Intervention**

Within this section is a general overview of the history and rationale for early childhood intervention, including the Individuals with Disabilities Education Act (IDEA) Part C program and Early Head Start, and a description of the need for speech-language pathologists (SLPs) in early intervention. The process within early intervention from the initial receipt of a referral to the development of the Individualized Family Service Plan (IFSP) is presented. A sampling of information is shared for respectfully working with our

culturally and linguistically diverse young clients and their families. The Part C driving philosophies for delivering services within natural environments and coaching parents and primary care providers to be the facilitators of the intervention strategies, during daily routines, is emphasized in two chapters. Finally, in this section, the strength found in the collaborative efforts among service providers is reviewed utilizing scenarios to illustrate varying situations.



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# 1

## What Is Early Childhood Intervention?

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### Introduction

Humans are a vastly diverse species. It is our evolutionary process to move forward generation after generation altering and adapting as we progress to continually better ourselves—at least that’s the ideal. But, for some, individual differences may cause disabling circumstances that require intervention supports and/or accommodations to survive and successfully access the world.

In **early childhood intervention**, we support infants, toddlers, and their families in positive, healthy, nonintrusive ways so that they can best access their daily living situations. Early childhood intervention could simply be defined as efforts to prevent or reduce challenges for a child, especially if it is thought that those challenges might increase in severity later

in life, such as in school. Early intervention (EI) allows for modifications so that children and families can access daily life circumstances in ways that best fit their means and situations. (Please note that the terms *early intervention* and *early childhood intervention* are often used interchangeably, including in this text.)

Children enter our world eager to learn, ready to absorb the environment around them, and open for relating with others. Most children quickly and naturally synchronize with the rhythms of those nearby. In most cases, communication happens almost instantly from that first breath at birth. Infants access information in many ways as they reach out to discover, experiment through their senses, and utilize all the means they’ve been gifted by being human. But not all children possess the sensory capacities to access the new world outside the womb.

## Explaining Early Childhood Intervention

Not all children are born with fully functioning eyes to see the world around them, which can be very difficult to ascertain within the infant and toddler population, but can readily disrupt early development. According to the U.S. Department of Education, in 2010 nearly 3,450 children ages 3 to 5 years were diagnosed with some degree of a visual impairment, which, for some, was present from birth (Visual Impairment, 2015).

Not all are born with ears to accurately hear sound moving through the air. Two to three out of every 1,000 children born in the United States present with a detectable level of hearing loss in one or both ears at birth as determined through newborn hearing screening and early hearing assessments (National Institute on Deafness and Other Communication Disorders, 2015).

Most infants worldwide are born into bi-/multilingual and/or bi-/multicultural lives reaping linguistic, cognitive, and sociocultural benefits. Yet the United States is in the minority of nations around the world. In the United States, monolingual homes are the norm. Being bi-/multilingual in the United States presents challenges in schools and communities, let alone in politics. In the United States, infants born hearing more than one language and/or exposed to more than one culture may experience challenges from early on.

Many infants are born into homes mired in poverty. The National Center for Children in Poverty states that in 2013, more than 16 million children under the age of 6 years in the United States (22%

of all children) lived in homes where the annual income was below the federal poverty level of \$23,624 for a family of four (National Center for Children in Poverty, 2014). With poverty, not always, but sometimes, violence and substance abuse exist—lives are a daily taxing reality.

When living in poverty, family concerns revolve around meeting basic needs: being able to regularly buy fresh fruit and vegetables; to have meat or fish daily; to have adequate clothing and two pairs of shoes; to have a dry home with hot water available; and to have access to good health care and education (Hyson & Biggar Tomlinson, 2014). On poverty-level income, it can take tedious planning, flexibility, perseverance, prioritization, and resourcefulness to make difficult decisions daily to maintain family stability. Love is deep, relationships are strong, and community members watch out for each other. But because meeting basic needs is prioritized, infants may not receive the undivided attention throughout the day that they need to connect to the rhythms of life, creating internal disorganization that may thwart emotional stability and eventual positive self-confidence.

The **World Health Organization (WHO)** examines how well those with **disabilities** function in their daily lives: caring for themselves, accessing and using knowledge to manage life skills and civic life, and socializing with others in the community. These are all skills that commence development in the very early years of life. In order to utilize a worldwide common language about disabilities and health within health-related sectors, the WHO developed a universal classification system. The WHO's **International Classification of Functioning, Disability**

**and Health (ICF)** considers functioning abilities at the level of the body, the whole person, and as the whole person within a social context (Table 1–1). Some of the formal definitions relating to disability include the following:

- **Activity Limitations**—difficulties in executing activities, including communication, interpersonal relationships and interactions, and community, social, and civic life
- **Participation Restrictions**—difficulties in life situations, including communication, and learning and applying knowledge

- **Environmental Factors**—problems in the physical, social, and attitudinal aspects in which people live and conduct daily lives (World Health Organization, 2002)

Federal law entitlements in the form of the **Individuals with Disabilities Education Act (IDEA)** accommodate those with disabilities, with **Part C** specifically accommodating the needs of our youngest citizens (birth to 3 years old). In 2014, about 2.95% of the U.S. population or 350,581 children were served through Part C, early intervention programs (Part C National, 2016). How did these services come about?

**Table 1-1.** World Health Organization’s International Classification of Functioning, Disability and Health (ICF) Relating to Early Intervention and Speech, Language, Communication

<b>Body</b>	
<i>Function:</i>	<i>Structure:</i>
Mental Functions	The Eye, Ear, and Related Structures
Sensory Functions and Pain	Structures Involved in Voice and Speech
Voice and Speech Functions	Structure Related to Movement
Movement-Related Functions	
<b>Activities and Participation</b>	<b>Environmental Factors</b>
Learning and Applying Knowledge	Support and Relationships
General Tasks and Demands	Attitudes
Communication	
Self-Care	
Domestic Life	
Interpersonal Interactions and Relationships	
Community, Social, and Civic Life	

Source: Adapted from WHO ICF (2002), p. 16.

**Box 1-1. Scenario One**

As Shanelle, SLP, entered the small child care in the basement of a neighborhood home, she spotted Molly, who looked up and smiled from across the room. Shanelle noted that even though Molly's mother reported she currently had a double ear infection, Molly appeared to have heard her greeting to Barb, child care provider.

Eventually, Molly approached and handed over a small doll. Shanelle accepted the doll as an invitation to join Molly in her doll play. She followed Molly to the child-sized kitchen area, knowing that this was a favored activity.

Shanelle had been seeing Molly for several weeks but had only heard very occasional utterances, some of which were recognizable words. Because Shanelle had observed Molly using many gestures to indicate her wants and needs, she coached her parents and Barb to present easy signs for Molly to use in her daily routines, such as *more, eat, drink, all done, help*. When

Shanelle arrived this day, Barb indicated that earlier, she had witnessed Molly signing *more*.

As Molly and Shanelle engaged in play in the kitchen area, Shanelle used a combination of oral labeling and sign to communicate with Molly. Holding back on a second cookie that Molly tried to reach for from Shanelle's hand, Shanelle signed and asked, *more?* Molly quickly tapped her hands together and vocalized /m/. Shanelle handed over the cookie, smiled broadly, and repeated, *Yes, more, more cookie*. Shanelle pretended to eat another cookie, while signing and saying, *eat*. Molly looked at her, then tapped her own mouth in imitation, followed by placing a cookie to her lips. *Yes, Molly, eat. Eat the cookie.*

It was appearing as though Molly, her parents, and Barb had done their homework during the week. Molly was acquiring conventional communications to indicate her wants and needs.

The rewards of seeing early communications from children who previously were nonverbal or struggling are plentiful and keep us returning to our jobs each day. Seeing Molly progress to these supportive gestures that could be understood by others close to her in a short time made the team feel successful. These successes keep early intervention moving forward.

**Brief History of the  
Development Toward Part C**

In 1975, **Public Law (PL) 94-142**, entitled *Education for All Handicapped Chil-*

*dren Act*, a landmark federal law, was enacted to support states and local communities in the United States, to protect the rights of, meet the individual needs of, and improve access to education for all children and youth with disabilities between the ages of 3 and 22 years. Throughout the United States, all persons with disabilities between these ages were ensured **special education** and **related services**. Birth to 3-year-old children may have received services sporadically, but these services were not covered by law. There were four main purposes of PL 94-142 as listed in Box 1-2.

These purposes ensured appropriate individualized education for all, protected by legal and available rights, and state and

local financial supports. Programs were to be audited to ensure adherence to the original purposes of PL 94-142 (OSEP, 2000).

In 1986, PL 94-142 was amended into **PL 99-457** to include children birth to 3 years of age. Now, very young children were also entitled under the law to receive support services as necessary. In 1997, PL 99-457 was further amended and retitled the Individuals with Disabilities Education Act (IDEA) protecting the rights of children and youth from birth to age 22 years. Within IDEA, there are four basic parts (APA, 2016) listed in Box 1–3.

IDEA's four parts range from providing definitions of the act to guidelines for working with individuals from birth through age 21 years to resources available to improve opportunities for those accessing IDEA benefits.

### **Individuals with Disabilities Education Act IDEA, Part C**

The focus of this text is on early childhood intervention—Part C of IDEA. Infants and toddlers (birth to 3-year-olds) with disabil-

#### **Box 1–2. Four Main Purposes of PL 94-142**

- To ensure that all children and youth with disabilities can access a **free appropriate public education (FAPE)** with emphasis on special education and related services to meet individual needs (*appropriate individualized education for all*)
- To ensure that the rights of the children and youth with disabilities and their parents are protected (*legal and available support for rights*)
- To assist states and localities to provide for the education of all children and youth with disabilities (*state and local financial support*)
- To assess and ensure the effectiveness of these efforts to educate all children and youth with disabilities (*auditing programs to ensure accountability and maintain the original purpose*)

(Adapted from OSEP, 2000)

#### **Box 1–3. Individuals with Disabilities Education Act (IDEA) Parts A–D**

**Part A:** definitions and foundation for the Act

**Part B:** identification and educational guidelines for the school-age population (3- through 21-year-olds)

**Part C:** identification and service provision guidelines for the birth through age 2 population and their families

**Part D:** national activities to improve the education of children and youth with disabilities along with their families. Examples include grants to improve educational opportunities and **transition** services between programs; resources to support programs, projects, and activities.

(Adapted from APA, 2016)

ities or **developmental delays**, and their families fall under this Part C section. Part B ensures services for 3- through 21-year-olds with disabilities. Those receiving Part C services may transition into Part B of IDEA on their third birthday provided continued eligibility and need for services are established. Provisions are made for smooth transitions from one program to the next.

Within IDEA's Part C regulation **§303.21**, an infant or toddler with a disability is defined as a child under the age of 3 years who requires early intervention services due to: (a) experiencing a developmental delay (as measured by appropriate diagnostic instruments and procedures) in one or more of the following areas:

- cognition
- physical (including vision and hearing)
- communication

- social or emotional
- adaptive

or (b) who has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay at some point. Also, included in this definition are children diagnosed with chromosomal abnormalities, genetic or congenital disorders, sensory impairments, inborn errors of metabolism, nervous system disorders, congenital infections, severe attachment disorders, and disorders secondary to exposure to toxic substances (e.g., fetal alcohol syndrome). At the discretion of each state, infants and toddlers considered to be **at-risk for developmental disorders** (**§303.5**) in the future may also be eligible under the Part C regulation (*Federal Register*, 2011).

Part C ensures the four elements listed in Box 1–4 are at the forefront of programming for families.

#### **Box 1–4. Four Elements of Part C**

- Every family with an infant or toddler having a disability or developmental delay is entitled to appropriate, timely, and **multidisciplinary** identification and intervention services for their child. (*right for inclusion in Part C multidisciplinary services*)
- Families are required to receive a plan for priorities, resources, and concerns of the family. This plan is called the **Individualized Family Service Plan (IFSP)**. The IFSP includes individualized program goals, a list of services to be provided to the child and family, and steps for transitioning out

of the EI program. (*plan of action*)

- Families have the right to participate in the creation of the IFSP and must give consent for the programming to commence prior to the initiation of the intervention services. (*creation and consent of the plan for services by family*)
- Parents or legal guardians are entitled to a timely resolution of all conflicts or complaints regarding the **evaluation** or services provided to their child. (*resolution steps developed if programmatic issues arise*)

(Adapted from APA, 2016)