

Foundations of Service Provision in the New Jersey Early Intervention System

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Introduction

Providing early intervention to children and families is a challenging and exciting job. The intervention you will be providing will enable families to meet the developmental and health needs of their infant or toddler. Effective intervention is an active, ongoing process that helps families receive information and learn and benefit from your clinical expertise, encouragement and support. Professionals in early intervention have the wonderful opportunity to work with families when their children are very young and they are just learning about their child's disabilities, delays and health needs.

- ❖ The recipient of early intervention services is the **family**.
- ❖ The recipient of intervention is the **child**.

Colorado IFSP Training, Module 3 Supports and Services, 2004.

Purpose

This self-study guide is an opportunity to learn the foundations of early intervention and the attitudes that are necessary to be successful as a practitioner in the New Jersey Early Intervention System (NJEIS). During your first year of employment as a practitioner, you will be required to complete all the orientation activities that are offered by the state Comprehensive System of Personnel Development and your local agency. Completion of this self-study guide and its accompanying open-book test will fulfill the first of these requirements.

Successful completion of the orientation materials will give you additional knowledge and skills that are necessary in your role as a competent early intervention practitioner. This self-study guide will provide you with the critical historical, legal, philosophical and professional foundations of early intervention.

Who are early intervention practitioners?

Practitioners come to early intervention from a wide variety of educational backgrounds and personal experiences. Practitioners' titles and their educational backgrounds are not always the same as the services they may provide. For instance, a licensed physical therapist is qualified to provide: physical therapy, developmental intervention, service coordination (when hired by a Special Child Health Services (SCHS unit)) or family training/counseling, and home visits in the NJ early intervention system. Early intervention services are provided by individuals of a variety of disciplines who meet the state personnel standards.

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: Complete descriptions of personnel requirements for each professional
: discipline can be found at:
: <http://www.eikids.com/nj/matrix/docs/pdfs/NJEnrollmentChecklist04132004.pdf>
:

Federal law (Individuals with Disabilities Education Act) and the NJ State Plan for Early Intervention specify that the following services may be included on an eligible child's Individualized Family Service Plan (IFSP):

- Assistive Technology Devices and Assistive Technology Service
- Audiology
- Family Training, Counseling and Home Visits
- Health Services
- Medical Services
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Service Coordination
- Social Work Services
- Special Instruction (Developmental Intervention)
- Speech-Language Pathology
- Transportation and related costs
- Vision Service

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: <http://www.state.nj.us/health/fhs/partc.pdf>
: provides a complete definition of each service
:

Early intervention orientation learning opportunities are designed to assist individuals who are already competent in their professional discipline, to become knowledgeable about the subspecialty area of early intervention.

Historical and Legal Roots of Early Intervention

Early intervention, like many helping professions, is value-laden work. One can choose many different ways to speak to, and about families, and many different approaches when supporting families. The purpose of this section is to assist you to further develop your personal value system about young children with disabilities and their families by acquiring a basic understanding of the history of how services evolved. As we read historical accounts from years past, specific words arise that are considered unacceptable in contemporary language. Those words are included here to relate the actual facts of the time period as well as demonstrate how values and behavior in society change over time.

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: For a very complete and enlightening understanding of the history and :
: sociology of disability, the interested reader is encouraged to visit the :
: web site of the Minnesota Council on Developmental Disabilities and :
: view its presentation "Parallels in Time," at: :
: <http://www.mncdd.org/parallels/index.html> :
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Evolution of Societal Attitudes Toward People with Disabilities

The roots of modern special education and psychology can be traced to the 17th and 18th centuries when Thomas Hobbes and John Locke undertook the study of human nature. Prior to that time the predominant attitude was scornful of people with disabilities and it was assumed that their condition was unchangeable. Locke advanced his theory of the mind as a "tabula rasa," or blank slate, upon which ideas are derived from the senses and through reflection. This theory supported the notion that persons with disabilities were blank slates who could also build ideas in their minds.

In 1801, Jean-Marc Gaspard Itard developed an individualized educational program for Victor, the "Wild Boy of Aveyron," France, a child who had been abandoned by his parents and lived alone in the woods (Plucker, 2003). Itard saw the opportunity to teach Victor as a way to test Locke's blank-slate theory. Although Victor did not make the great strides that Itard

expected, his progress did prove that children with developmental delays could learn and improve their abilities.

In the early 19th century, living conditions for people in poverty - which included most persons with disabilities - were quite harsh. In an era of rapid industrial growth in large cities, an interest in the living conditions of people with disabilities began to grow. Early attempts at classifying degrees of impairment utilized "imbecile" as a term to describe those with greater abilities than "idiots." Early social reformers such as Dorothea Dix spoke against the appalling conditions of those living in jails, poorhouses, and asylums across the United States.

During the middle of the 19th century, institutions for people with mental retardation, blindness and deafness began to grow in the United States. The intent of these institutions was to prepare people with disabilities to fit better into the world and to shelter them from society. The early training schools met with success, especially for persons with mild and moderate disabilities. This spurred an increased demand by families for placement in these institutions. Unfortunately, as the 19th century drew to a close, growing populations prompted many institutions to shift their focus to custodial care.

At the same time, the United States was undergoing enormous population growth due to immigration. Society was quick to blame problems on immigrant populations and to try to define them as mentally deficient. Institutions continued to evolve from places designed to shelter and teach people with disabilities to places to confine them in order to protect society. Overcrowding and inhumane conditions in these facilities worsened throughout most of the 20th century.

The early 20th century marked the beginnings of special education in the United States. Rhode Island was home to the first public special education classes. At this time, mental retardation was believed to result from genetic flaws and a lack of a moral upbringing. The label brought great stigma to both the individual and his/her family. The economic depression of the 1930s and continued stigmatization of mental retardation encouraged more families to seek institutional care for their children.

The 1940s and 50s marked a time of hope for parents of persons with disabilities who were frustrated over the poor living conditions and lack of training opportunities their children were experiencing. This period marked the beginning of the formally organized parent advocacy movement in the United States and saw the creation of advocacy and service organizations such as Arc of the United States (formerly known as the Association for Retarded Citizens) and United Cerebral Palsy. The initial intent of these organizations was to provide support for parents, many of whom had children living in institutions. These organized advocacy efforts helped to provide the impetus for the legal and legislative events that followed.

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: **Birth of the Parents' Movement**

: "Spontaneously, we had a worldwide revolution without really knowing what
: started it. They all said at the same time 'enough is enough'. And yet
: there was not one leader, not one movie or book, not one happening that
: affected everyone. In various countries, it started in various ways."

: Gunnar Dybwad, *Parallels in Time: The Reawakening*.

: <http://www.mncdd.org/parallels/index.html> .

: Minnesota Council on Developmental Disabilities, 2005
:

Litigation and Legislation

In 1954, the landmark court case, *Brown vs. Board of Education*, established the legal principle that education was a basic right, subject to equal protection under the 14th Amendment. Though this case applied specifically to racial segregation, it provided a foundation for special education cases arguing that separate was not equal.

President John F. Kennedy, whose sister Rosemary had mental retardation, formed the President's Commission on Mental Retardation, and in his brief time in office oversaw legislative projects authorizing funding for direct services and research. The 1960s also saw a visit to Willowbrook State School in New York by Senator Robert Kennedy and a television crew. Syracuse University Professor Burton Blatt and photographer Fred Kaplan visited other public institutions. Blatt and Kaplan's book, Christmas in Purgatory, demonstrated the inhumane conditions of the residents in graphic detail. These exposés helped to support growing pressure for

deinstitutionalization, the concept of ceasing to admit people to institutions and returning residents to the community.

In 1964, Congress passed the Civil Rights Act, affirming the court's determination in *Brown vs. Board of Education* that separate is not equal. In 1965, the Elementary and Secondary Education Act (ESEA) was passed, providing federal funding to states for special education services.

The 1972 *PARC* case was a class action suit against the state of Pennsylvania on behalf of children with mental retardation who had been excluded from public education. This case laid the foundation for many important principles of current special education law, including: the right to a free, appropriate public education (known as FAPE); least restrictive environment (known as LRE) and the right of parental participation. The 1972 *Mills* decision, meanwhile, established the right of "zero reject," meaning severity of disability may not be used as a reason to exclude a child from special education services, and the right of families to "due process", that is, to have a means of disagreeing with their school about a child's educational services.

These court cases helped lead to the landmark 1975 legislation known as P.L. 94-142, the Education of the Handicapped Act (EHA). This law mandated the provision of a free, appropriate, public education, in the least restrictive environment, for all eligible school age children. It allowed for, but did not mandate, service for children from birth to five years of age.

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Did you know?

- ✓ **P.L. means Public Law**
- ✓ **94 means it was passed by the 94th Congress**
- ✓ **142 means it was the 142nd piece of legislation passed**

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The 1986 reauthorization of EHA, P.L. 99-457, mandated preschool services for children from three to five with disabilities and offered funding to states for eligible birth to three-year-olds through the section of the law known as "Part H" or "early intervention". In 1991, P.L. 102-119 reauthorized amending the law and changing its name to the Individuals with Disabilities Education Act, often known as IDEA. 1997 saw the next reauthorization of IDEA, which moved early intervention services from Part H to Part C of the

law and strengthened the requirement that states provide early intervention services in natural environments. Congress defined natural environments as the places where children without disabilities spend their time and where the child would be if s/he did not have a disability. 2002 began another reauthorization process which was signed by President Bush on December 3, 2004.

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**Read the full text of IDEA '97 and
the latest information on the reauthorization, online:
http://www.cec.sped.org/law_res/doc/law/index.php**
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In 1990, the Americans with Disabilities Act (ADA) was signed into law. This landmark legislation requires that all public accommodations (including businesses and schools that do not receive any government funds) make reasonable accommodations to allow the full participation of individuals with disabilities. This law covers the inclusion of children with disabilities in public and private child care settings.

.....
**Visit the US Department of Justice's ADA home page at:
<http://ada.gov/> to learn what the ADA says about child care and
children with disabilities.**
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Locally, New Jersey passed Chapter 415 in 1981. It mandated the implementation of the federal Education of the Handicapped Act and established the Department of Education as the lead agency for special education. New Jersey began participating in Part H in 1986 under the Department of Education. In 1992, New Jersey passed Chapter 155, which reassigned lead agency status for early intervention to the Department of Health and Senior Services. Please see the "Legal History at a Glance" provided at the end of this document.

In your day-to-day work as a practitioner, you will not be asked to recall specific details about the purposes of the first institutions for people with disabilities in our society. You will be asked to work with families in a way that supports them to develop positive expectations for their child with a disability, their participation in community life and their view of

themselves as future agents of change. You will have an important responsibility to support and assist families of children with disabilities.

Knowledge of our social and legal history about the treatment of people with disabilities can help us chart a future path and avoid repeating mistakes from the past. When the law is vague about how to proceed or what to say, recall what history has taught us about practices that devalue the lives of people with disabilities. Remember the efforts of family members to advocate and support legislation to ensure that their children have the right to education that allows them to develop to their fullest potential. Keep in mind the commitment that our country has made to value the lives of all citizens.

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IDEA 1997 Preamble:
"Disability is a natural part of the human experience and in no way diminishes the right of individuals to participate in or contribute to society. Improving educational results for children with disabilities is an essential element of our national policy of ensuring equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities."
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The Individuals with Disabilities Education Act (IDEA)

Part C of IDEA contains the regulations governing the implementation of early intervention by participating states. Although participation is voluntary, all 50 states are currently implementing Part C of IDEA.

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General Components of IDEA
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❖ **Part A: General Provisions**
❖ **Part B: Education for All Children with Disabilities, 3-21 years of age**
❖ **Part C: Early Intervention for Children Birth to Three**
❖ **Part D: National Activities to Improve the Education of Children with Disabilities**
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Part C provides financial assistance to states to:

- Develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with developmental delays and disabilities and their families;
- Facilitate the coordination of payment for early intervention services from federal, state, local and private sources;
- Enhance the state capacity to provide quality early intervention services and expand and improve existing services;
- Enhance the capacity of state and local agencies and service providers to identify, evaluate and meet the needs of historically underrepresented populations, particularly minority, low income, inner-city, and rural populations.

As this list demonstrates, Part C funds were intended to encourage states to coordinate the use of existing resources, not to create a new program. Congress recognized that the needs of infants and toddlers and their families are complex and often cross agency and disciplinary boundaries. Federal funds were intended to increase the quality of early intervention and access to it, especially by families who have historically found it difficult to utilize services.

The purpose of early intervention is to enhance the development of infants and toddlers with disabilities AND to enhance the capacity of families to meet the unique developmental and health needs of their infants and toddlers with disabilities. Infants and toddlers cannot grow and develop outside a family. The family can be defined in many ways---one parent, grandparent, foster parents, etc---but infants and toddlers are uniquely dependent on their family, however it is defined, to nurture, feed, protect, and love them. Recognition of the central role of the family led to the Individualized Family Service Plan (IFSP) as the document that outlines how early intervention will help and support a particular child and family.

New Jersey Plan for Implementation of Part C

Each state must submit an annual plan to the federal government that describes how it will implement the required components of Part C.

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: New Jersey State Plan for Early Intervention:
: <http://www.state.nj.us/health/fhs/partc.pdf>
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In this section, we will explain how New Jersey is implementing each of these required components.

1. The first of the key components is the establishment of a single line of authority, designated by the governor, with overall responsibility for the state early intervention system. New Jersey has chosen the Department of Health and Senior Services as the lead agency for early intervention services. (See attached flow charts). The lead agency contracts with four regional early intervention collaboratives (REICs) to oversee the regional administration and capacity-building of the New Jersey Early Intervention System (NJEIS). (See the New Jersey Organization Overview chart provided at the end of this document.)

2. Each state must establish its own definition of developmental delay and establish criteria for eligibility for early intervention. New Jersey has defined three components of eligibility for children between birth and 36 months of age:

I. Developmental Delay

A. Is measured with appropriate diagnostic instruments, procedures, and clinical opinion in the following areas of development:

- ❖ Physical (gross motor, fine motor and sensory: vision and hearing)
- ❖ Cognition
- ❖ Communication
- ❖ Social or emotional
- ❖ Adaptive

B. A child must have at least 25% delay in 2 areas of development or at least a 33% delay in one area of development

C. Adjusted age for premature infants is based on 40 weeks term. There is no adjustment for infants born at or after 38 weeks gestation. Age adjustment ends at 24 months of age.

II. High Probability of Developmental Delay

A. Conditions with High Probability (federal)

- a. Children are eligible who have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay AND
- b. Who have a signed statement or report from a physician or psychologist indicating that the condition for this child has a high probability of developmental delay
- c. Conditions with High Probability (federal) include:
 - ❖ Chromosomal abnormalities
 - ❖ Genetic or congenital disorders
 - ❖ Severe sensory impairments, including vision and hearing
 - ❖ Inborn errors of metabolism
 - ❖ Disorders reflecting disturbance of the development of the nervous system
 - ❖ Congenital infections
 - ❖ Disorders secondary to exposure to toxic substances, including fetal alcohol syndrome
 - ❖ Severe attachment disorders

B. Presumptive Eligibility (New Jersey)

- a. New Jersey has created a "short list" of diagnoses from the federal list of conditions that include:
 - ❖ Down syndrome
 - ❖ Fetal alcohol syndrome
 - ❖ Hearing impairment
 - ❖ Vision impairment
 - ❖ Autism/PDD
 - ❖ Spina bifida
 - ❖ Cerebral palsy
 - ❖ Trisomy 13, 18, etc
 - ❖ Fragile X
 - ❖ Hydrocephalus

- b. Children who have a presumptive diagnosis are considered eligible even in the absence of delays at the time of referral.
- c. Written verification of the diagnosis must be included in the child's records. Presumptive Eligibility does not require a written statement about high probability.
- d. Upon referral, no evaluation is required and the child proceeds to assessment for IFSP planning. Outcomes and services needed at any time during eligibility are determined by assessment findings and the IFSP team.
- e. Service coordination is provided to all eligible children.

III. At Risk of Developmental Delays

- A. Children at risk for developmental delay are not eligible for services unless they otherwise meet the criteria established for high probability or presumptive diagnosis.

High probability and presumptive eligibility both include children who may not be exhibiting delays at the time of diagnosis. Service coordination is provided to all eligible children. Level of service beyond service coordination is determined at periodic intervals throughout eligibility and is based on the child's and family's needs and the outcomes in the IFSP.

3. Comprehensive (looking at all areas of development), multidisciplinary (by at least 2 professionals of different disciplines) evaluation of a child to determine eligibility is another required component. In New Jersey, each county has a Targeted Evaluation Team that provides these services at no cost to the family. The service coordinator and evaluation team work together with the family to plan an appropriate evaluation.

4. Each eligible child must have an Individualized Family Service Plan (IFSP) developed by an IFSP team, within 45 days of referral, which always includes at least the family and the service coordinator. Initial IFSP meetings include at least one member of the evaluation/assessment team.

5. With the family's consent, we gather information from them about their concerns, priorities and resources related to the child's development and consider this information when developing an IFSP.

6. Public Awareness and Child Find Activities are coordinated with the Part B special education system. There is a shared toll-free phone number for referrals for children from birth to age 21. Special Child Health Services Case Management Units, located in all 21 counties, serve as the single point of entry into the NJEIS.

7. A central directory of resources is maintained in cooperation with the Department of Human Services, Division of Disability Services, through the annual publication of the Resources guide. This guide is distributed to all service coordinators and through them to families in early intervention.

8. The Comprehensive System of Personnel Development (CSPD) provides training and technical assistance opportunities through a network of Training and Technical Assistance Coordinators and Project Specialists located in the REICs.

9. Procedural safeguards assure that families have a method to address their disagreements with the NJEIS. These rights are detailed in the "Family Rights" document which is distributed to all families.

10. Data is collected from each early intervention agency and is sent to the DHSS for review and submission to the federal government and can be found at: <http://www.ideadata.org/PartCdata.asp> .

11. The DHSS is responsible for maintaining a system to contract for service provision or otherwise arranging for services. In New Jersey, this system consists of a network of private and public agencies that are reimbursed through the DHSS.

12. All families of children who are eligible for early intervention must be provided with service coordination at no cost to the family. Details on the federal requirements for service coordination are found in the following section.

Funding and Arranging for Early Intervention Services

IDEA does not specify that a state must provide and pay for the direct services that are described in an IFSP, or how much service must be

supplied. IDEA does say that if there is a cost to families, there must be provisions made for families who are not able to pay. Each state has established its own funding mechanisms within the parameters defined by IDEA. Regardless of the funding mechanism used, all IFSPs must state the intensity, frequency and type of service(s) that the child and family need to meet the outcomes in their IFSP.

Effective March 1, 2004, all families participating in early intervention in New Jersey share in the cost of early intervention services through the payment of a monthly "family cost share." This payment will be the same regardless of the number of hours per week that are specified in the IFSP.

Families whose incomes are below 350% of the federal poverty level (FPL), for family size, are deemed to have an "inability to pay" and will receive all IFSP services at no cost to them. When a family's income is at or above 350% FPL for family size, they are required to share in the cost of early intervention services beginning at a base fee, with progressive increases based on income.

It is the responsibility of service coordinators to verify and document the family income information. This information is confidential and is not shared with practitioners.

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: To better understand how family cost share is computed please read:
: **"Financial Participation Guidelines: Early Intervention System,"**
: http://www.state.nj.us/health/fhs/cost_participation.htm
:

Service coordinators are responsible for locating service providers to meet the requirements of an IFSP. This is done by contacting the comprehensive service provider agency in the family's geographic catchment area. If the comprehensive agency is unable to provide one or more of the needed services, the service coordinator will contact a service vendor agency. The NJEIS values each family having a comprehensive early intervention "home" from which they will receive coordinated services. When that is not possible, service vendors are utilized until an opening is available within the comprehensive agency.

Procedural Safeguards

Practitioners and service coordinators must be intimately familiar with the rights, procedural safeguards, and services to which families are entitled and utilize a variety of listening, speaking, and teaching skills to inform and remind families about their rights through all the different phases of their child's time in early intervention. IDEA indicates that a central role of the service coordinator in early intervention is to assure that the family receives full protection of its rights. However, the education of families about and protection of their rights is a shared responsibility of everyone in early intervention.

Some families would prefer to read the family rights booklet and call with follow-up questions. Others may not be able, or inclined, to read the booklet and would prefer a conversation about their rights. During every discussion with families about their IFSP content and services, the practitioner must ask him/herself which rights and procedural safeguards are involved and remind the family which apply to the current situation. Sometimes this notification is required in writing. Written notification is handled by the family's service coordinator. This is one of the many reasons that IFSP changes are never made without the involvement of at least the parent and service coordinator. When written notification is not required, the rights of families must be discussed and documented in ongoing notes.

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The documents Family Rights and
New Jersey Procedural Safeguards Guidelines can be found at:
<http://www.state.nj.us/health/fhs/procsafeguards.htm> .
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There are six key areas in which procedures have been developed to protect the rights of children and families:

1. The Right to Informed Parental Consent

Families must understand all information about early intervention and give voluntary written permission for service. Informed consent must:

- Be explained in language parents understand;
- Be completed in writing;
- Be voluntary and may be revoked at any time;
- Explain family responsibilities (For example, parent has agreed to transport child to play group 1X/week);

- Explain that families may consent to some services and not others (for example, the parent would like an assessment by a physical therapist but not an assessment by a speech therapist. ;
- Explain adverse consequences of denying consent (for example, the child would not be able to have the services of a speech therapist to address communication needs if consent for a speech assessment were not given); and
- Occur at the following events: evaluation/assessment, IFSP (initial, annual and reviews), release of information.

2. The Right to Written Prior Notice

Service coordinators must give families written prior notice at specific times during the early intervention process. Notice is required of initial evaluation/assessment, any IFSP meeting or review and prior to any implementation/change of service. The notice must be given in writing ten days prior to the event or meeting (The notice must explain what will happen, when, why, what, how and who. Parents may waive their right to ten days' notice.).

3. The Right to Examine Records

Parents can review their child's early intervention records at any time. They may request that incorrect or misleading information be revised or removed from the record, ask for copies of and view all records that pertain to their child and family.

4. The Right to Confidentiality

Parents must give their written permission before records can be shared with other individuals or agencies. Procedural safeguards ensure confidentiality of all personally identifiable information. Please see the NJEIS Resource Notebook for more detailed information on the Family Educational Right to Privacy Act (FERPA), including details on the legal requirements for release of records.

5. The Right to a Surrogate Parent

Eligible children whose parents cannot be identified or located, or who are wards of the state, have a right to a surrogate parent to represent them in matters pertaining to Part C. Surrogate parents are entitled to all the rights in early intervention given to biological parents.

6. The Right to Formal Dispute Resolution

Parents must have access to an impartial mediator or impartial hearing in the event that there are disputes which need to be resolved. Mediation is a voluntary, non-adversarial process for the resolution of disputes. Parents also have the right to request an impartial hearing to resolve any dispute.

Mediation and/or hearings may occur in disputes over:

- Identification;
- Eligibility Decision;
- Evaluation or assessment;
- Placement;
- Provision of early intervention services; or
- Violation of Part C timelines.

Additionally, administrative complaints may be filed by a parent, individual or organization that alleges that an early intervention program, service provider, service coordinator, REIC, the DHSS, or any other state agency involved in the early intervention system is violating or has violated a requirement of federal or state early intervention law or guidelines.

In addition to these general areas of parental rights, under Part C in New Jersey, parents have the following specific rights and safeguards:

- With written consent, the child and family have the right to a multidisciplinary evaluation and assessment and, if eligible, the development of an IFSP within 45 calendar days from referral;
- If eligible, and with written consent, the family has the right to appropriate early intervention services as addressed in the IFSP;
- Evaluation, assessment, IFSP development, service coordination and procedural safeguards are provided at no cost to the family. Families may be charged for other services on a sliding fee schedule. Inability to pay will not prevent a child or family from receiving services;
- Families are invited to participate in all meetings in which a decision is expected to be made regarding a proposal to change the identification, evaluation or placement of the child/early intervention service provision; and
- Early intervention services will be provided in the child/family's natural environment within the family's daily routines to the maximum extent appropriate to meet the child's needs.

All early intervention practitioners must be familiar with the general and specific rights of families in early intervention so that their work complies with these rights and so that they can explain them to families.

Service Coordination

Service coordination is one of the early intervention components that Part C of the federal Individuals with Disabilities Education Act (IDEA) requires all states to provide at no cost to eligible families. New Jersey has chosen to fulfill this mandate by providing service coordination through the 21 county-based Special Child Health Services Case Management Units.

Service coordinators in New Jersey are "dedicated" only to service coordination and do not provide any other early intervention services. Any early intervention professional who meets the state personnel standards for a designated early intervention discipline may function as a service coordinator. In many other states, one individual provides service coordination and other professional services that the child and family need. New Jersey's dedicated system demonstrates the state's strong commitment to providing service coordination that is unbiased and high quality.

Additionally, paraprofessionals may serve as Service Coordinator Associates. The Service Coordinator Associate position was created to better meet the needs of children and families. Service Coordinator Associates increase the resources of Special Child Health Services (SCHS) by including qualified parents and other community members who reflect the diversity of families served by SCHS in a particular county. The Service Coordinator Associate position is intended to provide support to the professional service coordinator to better meet the needs of all the families on his/her caseload.

Section 303.23 of IDEA defines service coordination as the activities performed by a service coordinator to assist and enable a child who is eligible for early intervention and their family to receive the rights, procedural safeguards and services that are authorized under the NJEIS. The law also requires that each eligible child and family must be provided with one service coordinator who is responsible for coordinating all services

across agency lines and serving as the single point of contact in helping parents obtain the services and assistance they need.

IDEA tells us that service coordination is an active, ongoing process that involves:

- Assisting parents in gaining access to early intervention services and other services identified in the individualized family service plan (IFSP);
- Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes that the child needs or is being provided);
- Facilitating the timely delivery of available services; and
- Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.

The service coordinator is responsible for seven specific activities:

- Coordinating the performance of evaluations and assessments;
- Facilitating and participating in the development, review and evaluation of IFSPs;
- Assisting families in identifying available service providers;
- Coordinating and monitoring the delivery of available services;
- Informing families of advocacy services;
- Coordinating with medical and health providers; and
- Facilitating the development of a transition plan from Part C to appropriate supports and services, which may include preschool.

Critical Features of Early Intervention

The New Jersey Department of Health and Senior Services, lead agency for early intervention, with the advice and assistance of the State Interagency Coordinating Council has adopted the following vision statement for early intervention:

"New Jersey will have in place an Early Intervention System which is driven by beneficiaries to provide early intervention services that are equitable, flexible, family-centered, culturally competent, community-based, coordinated and delivered in natural environments, which are continually

improving on each of these characteristics. These system-delivered services will be: available; accessible; affordable and appropriate”.

In this section, we will further explore what the implementation of this vision means to service coordinators in New Jersey.

Working Together as A Team

Early intervention practitioners and service coordinators work on many different teams during the course of any work day. Besides the team of professionals who are your colleagues at your office or agency, you are an important member of the IFSP team of every family with whom you work. This requires a commitment on the part of each individual and agency to value teamwork and allocate time for members to meet with each other.

Every child/family has an IFSP team which consists of themselves, a service coordinator, practitioners, evaluators/assessors and everyone who provides formal or informal support to the family(as they choose to include them). They are united by the common goal of supporting and strengthening the family in relation to the development of their child who has disabilities/delays.

Membership on a team with early intervention professionals may be a new experience for some families. Most professionals have prior experience and training in working on intervention teams. Early intervention teams can support families to comfortably participate by developing the following strategies:

- Sharing information in a manner that is understandable to the family to promote a high level of family involvement
- Role clarifying so that families understand the variety of ways they can participate within the team: as an observer, active participant or a facilitator, etc.
- Using common vocabulary facilitates family participation by limiting use of professional jargon and defining key terms.
- Recognizing that family concerns will sometimes take precedence over team goals. The team must be willing to address these concerns so that the parent can then use their resources to address the child's health and developmental needs.

- Scheduling meetings at a time and location that are accessible to the family will show respect and demonstrate commitment to their participation.

There are a variety of teaming models that may be used by early intervention teams to assist in accomplishing shared tasks. A model offers a structure that guides the team in accomplishing its goals. Teams often use components of different teaming models. Knowing the characteristics of various team models and the advantages and disadvantages of each can help early intervention professionals understand team interaction and communicate clearly with families about how their team will operate.

The teaming models used most often in early intervention are multidisciplinary, interdisciplinary and transdisciplinary. On multidisciplinary teams, members share common goals but work independently of one another to represent their own disciplines. Members of interdisciplinary teams also share common goals, but have made a commitment to communication among team members, including families. Transdisciplinary teams use a systematic process for sharing roles and crossing disciplinary boundaries to maximize communication, interaction and cooperation among members (Bruder and Bologna, 1993; Woodruff and McGonigel and Garland, 1988). Team members make a commitment to teach, learn and work together across disciplinary boundaries to implement coordinated services.

.....
: "The therapists were very nice and highly recommended. Unfortunately, :
: they worked with each other while I watched. The therapists did not :
: often include me in the actual "hands-on" therapy so I was not :
: comfortable trying at home what they did in therapy sessions". :
:
: Lorna Mullis, *Natural Environments: A letter from a mother to friends, families and* :
: professionals. Young Exceptional Children, 2002. :
:.....

The New Jersey early intervention system supports the use of interdisciplinary and transdisciplinary teams or a combination model as the most effective for working with young children and their families. The chart that follows demonstrates how interdisciplinary and transdisciplinary teaming strategies best support the family-centered approach of early intervention.

Three Models for Team Interaction

Component	Multidisciplinary	Interdisciplinary	Transdisciplinary
Philosophy of team interaction	Team members recognize the importance of contributions from several disciplines.	Team members are willing and able to share responsibility for services among disciplines.	Team members commit to teach, learn and work across disciplinary boundaries to plan and provide integrated services.
Family Role	Generally, families meet with team members separately by discipline.	The family may or may not be considered a team member. Families may work with the whole team or team representatives.	Families are always members of the team and determine their own roles.
Lines of Communication	Typically informal. Members may not think of themselves as part of a team.	Team meets regularly for case conferences, consultations, etc.	Team meets regularly to share information and to teach and learn across disciplines (for consultation, team building, etc.).
Staff Development	Generally is independent and within disciplines.	Frequently shared and held across disciplines.	Staff development is across disciplines and is critical to team development and role transition.
Assessment Process	Team members conduct separate assessments by discipline.	Team members conduct assessments by discipline and share results.	The team participates in an arena assessment, observing and recording across disciplines.
IFSP Development	Team members develop separate plans for intervention within their own disciplines	Goals are developed by discipline and shared with the rest of the team to form a single service plan.	Staff and family develop plan together based on family concerns, priorities and resources.
IFSP Implementation	Team members implement their own plan separately by discipline.	Team members implement parts of the plan for which their disciplines are responsible.	Team members share responsibility and are accountable for how the plan is implemented by one person, with the family.

McGonigel, Woodruff, Roszmann-Milican. The Transdisciplinary Team: A Model for Family-Centered Early Intervention.

Developing Effective Relationships with Families

One of the great challenges and pleasures of early intervention is developing effective, trusting relationships with a wide range of families. In order to develop these relationships, you must have a respectful and flexible prism for viewing the experiences of families of young children with disabilities. There is no one right way to view families, nor one right way to interact with them. Working with families is both an art and a science. The "science" part is getting the facts; the "art" part involves empathy, authenticity, and caring about the child, his/her family and their unique strengths and challenges.

"The word listen contains the same letters as the word silent"

Alfred Brendel, classical pianist, <http://www.dailycelebrations.com/listen.htm>, 2005

There are many different theoretical frameworks that have been applied to the experiences of families who have a child with a disability. These frameworks can be useful for helping to process reactions to the words and decisions of families which professionals often have difficulty understanding. Frameworks can also guide us in providing appropriately targeted support that assists families in meeting their goals for their infant/toddler and themselves.

One of the most commonly cited frameworks is the application of Elizabeth Kubler-Ross's landmark work, described in her book, On Death and Dying (1969), to the process of accepting a child's disability. Kubler-Ross described five stages of grief that are sometimes analogized to be the same as those which families experience when they learn that their child has a developmental delay or disability. These stages are: anger, denial and isolation, bargaining, depression and acceptance.

This framework offers insight into the emotional process families may be experiencing. Practitioners must understand that it offers a way of interpreting the context of what is happening in a family. It is not a way to diagnose or force a family to change their thoughts or actions. Professionals may be tempted to dismiss families' concerns or feelings when they believe that the family is in denial of their child's special needs/disabilities. Denial can be a useful mechanism that allows families to accomplish the tasks at

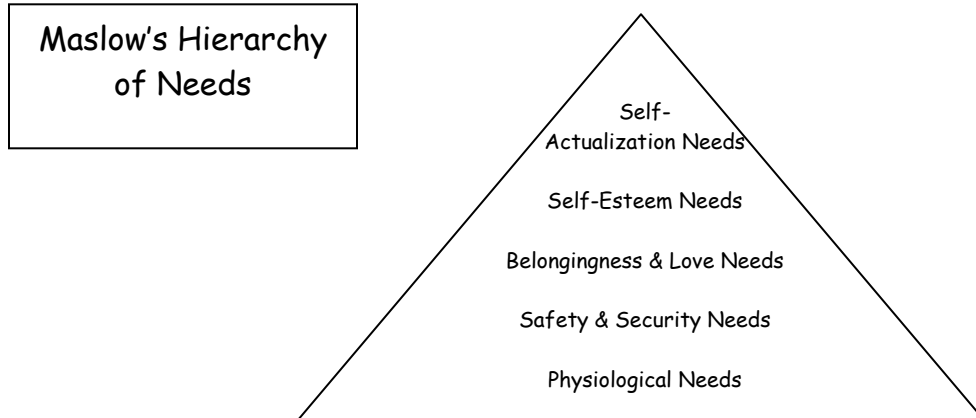
hand while not yet fully processing all the information they have been given about their child.

Shifting Your Perspective on Denial, Suggestions for Professionals:

- Support parents' hopes and dreams for their child.
- Suspend judgment of families and their behavior.
- Be patient. People need time to find their own personal way through unexpected events.
- View this time as an opportunity to strengthen trust.
- Educate other professionals and family members to rethink denial.

Gallagher, Fialka, Rhodes and Arceneaux, *Working with Families: Rethinking Denial*, Young Exceptional Children, 2002

Another framework that may be useful is the work of Abraham Maslow. According to Maslow's work, we all have needs that are hierarchical in nature. In order to be able to address a higher level need, one must feel that lower level, more basic needs are met (Boeree, 2003).



When families are coping with physiological needs, such as food and shelter, they are not able to address higher level needs such as love or self-esteem. The diagnosis or realization that an infant/toddler has a disability or special need may result in a crisis for the family which disrupts their ability to meet basic needs or causes them to question whether their love or self-esteem needs are being met (Texas Early Childhood Intervention, 2003).

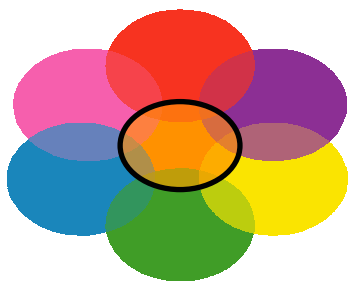
Some families in early intervention face daily struggles to meet their basic needs. The additional stress of parenting an infant or toddler with delays or disabilities may create great personal crises. Maslow's hierarchy of needs may help the practitioner to better understand the decisions a family makes about their concerns and priorities.

Another approach to family adaptation to disability describes four stages of adaptation: surviving, searching, settling in and separating (Miller, Burmester, Callahan, Dieterle and Niedermeyer, 1994). The authors describe specific coping strategies that families may use to guide them through the process of adjusting to their child's disability. Miller emphasizes that the stages of adaptation occur in order, but do not necessarily occur in isolation. They may co-exist with one another, serving as a background framework when new stresses, diagnoses, or life-cycle challenges may temporarily bring a particular stage to the foreground for a family.

Ann Turnbull, a parent of an adult with a disability and a researcher at the Beach Center on Disability at the University of Kansas, supports an evolutionary shift away from the psychologically-based models of family support. She believes those models assume that the family is not able to cope and is most likely evidencing "pathology" that professionals must help to change (Turnbull, Summers and Jackson, 2002).

Turnbull and colleagues describe a "Family Quality of Life" model which proposes that families will make positive adaptations to their child's disability if early intervention (and other service delivery systems) provides services that support the family to achieve their optimal quality of life. The family quality of life domains include; health and safety, family resources, family interaction, parenting, and support for persons with disabilities.

In this model, the five family domains provide the context within which individual family members form a collective family unit. Each circle in this diagram represents a family member. Individual family members influence each other. This may occur with the family member with a disability at the center of the family, or as one of many family members.



1. Member with Disability at Center of Family



2. Member with Disability as one of many family members

Diagram reprinted with permission of the authors: Turnbull, Summers and Jackson, 2002.

The Family Quality of Life model offers practitioners a framework for determining how early intervention can assist families to increase satisfaction with their lives as individuals or as a family unit in a broad range of environments. Using this approach, practitioners shape their relationships with families by building on the strengths and family-identified priorities for change.

"Entering into our partnership with you demands that we let go of our dreams and begin to build new ones. So we may not appear too eager or willing to join you in this partnership dance. To your open, welcoming arms, we parents may appear arrogant, withdrawn, hostile, and defensive. Some might refer to us as being "in denial". It is easy to see how you, as the professional might personalize the distancing attitude we seem to project with our folded arms and defensive posture. You may find yourself silently crying out to us, "I'm only trying to be helpful!"."

Janice Fialka, *The Dance of Partnership*, Young Exceptional Children, 2001.

In your role as a practitioner, at times, you may feel frustrated, confused or even angry with families because of the choices they are making for themselves and their infant/toddler. By your behavior with the family, both verbal and nonverbal: spoken (tone, words used) and unspoken (metacommunication- body language, attentiveness), you send a message to the family as to what you are thinking and feeling. The family will sense and respond to warmth, genuineness or coldness, real involvement or façade, immediacy or remoteness. You are encouraged to do further reading (see

bibliography) and seek support from your supervisor to process your responses to families.

Family-Centered Services

Just as attitudes toward people with disabilities have evolved over time, so have our beliefs and attitudes toward families of children with disabilities. One of the beliefs central to the delivery of early intervention services is that they should be family-centered. At the core of this philosophy is the recognition that the family is central to all that happens in a young child's life. Services that focus on the child in isolation from the family's wishes, objections, needs or concerns are doomed to failure. Family-centered early intervention practices celebrate the family's knowledge and expertise in their child. The IFSP team would be incomplete without the input of the family members who are the experts on their child.

.....
: "Now that I have suggested some approaches at home, what have I
: missed? How will this change or disrupt your life? How will this
: complicate your daily living? What do I need to understand from your
: side as the parent?"
:
: Janice Fialka, The Dance of Partnership, Young Exceptional Children, 2001.
:.....

The family-centered approach also supports one of the main purposes of early intervention: to enhance the family's capacity to meet their child's health and developmental needs. Family-centered practices always enhance the family's feelings of competence in nurturing their child.

IFSP team members may feel at times that they know better than the family what a child needs in order to grow and thrive. Early intervention providers must share their clinical skills and knowledge with the family and make appropriate recommendations. The family must decide how it will use the recommendations and what services it will choose to accept and integrate into their daily routines. When a family rejects a recommendation from early intervention, we must evaluate how we gave the information and consider when and how it would be appropriate to address these issues again. The purpose of early intervention is to support- not reduce-the autonomy and confidence of the family. No matter how medically fragile or developmentally delayed a child might be, the purpose of early intervention

is to promote the family as the center of the child's world- not therapists, teachers or doctors. Supports and services must be meaningful to the family for them to have a meaningful impact on the child.

.....
: "If I knew for a certainty that a man was coming to my house with the
: conscious design of doing me good, I should run for my life."
:
: Henry David Thoreau, author and philosopher
: <http://www.brainyquote.com/quotes/quotes/h/henrydavid163106.html>, 2005
:.....

Cultural Competence

Inherent in the early intervention approach is the acknowledgement that every family possesses a unique culture. The early intervention provider understands and respects the family's cultural rules and boundaries. Services are delivered within those rules and boundaries to be meaningful to the family. Early intervention can only be truly successful when families feel ownership of the activities and interventions.

.....
: **What is a Family?**
: "Families are big, small, extended, nuclear, and multi-generational, with one
: parent, two parents, and grandparents. We live under one roof or many. A family
: can be as temporary as a few weeks, as permanent as forever. We become part
: of a family by birth, adoption, marriage, or from a desire for mutual support....A
: family is a culture unto itself, with different values and unique ways of realizing
: its dream; together, our families become the source of our rich cultural heritage
: and spiritual diversity... Our families create neighborhoods, communities, states
: and nations."
: Reprinted from: Colorado Service Coordination Core Training, 2001
: Source: Task Force on Young Children and Families, New Mexico Legislature
:.....

Natural Environments

Natural environments are places where the child and family would spend their time if the child did not have a disability. Another way of describing natural environments is to say that early intervention services are most meaningful and effective when they are delivered in the everyday routines, activities and places where the family typically spends time. This might mean working in the family's home, but it also means that early intervention

might be provided at child care, the park, a grocery store, a grandparent's home, or the library.

"Natural environments" refers to so much more than a physical setting. Children learn from the ordinary activities of everyday life. The purpose of early intervention is to support the family in learning intervention strategies and integrating them into the fabric of their lives. All children and families have the right to live, work, worship, and play in the community where they live.

.....
: "What are Routines?
:
: Routines are not necessarily things that happen routinely. They are simply
: times of day. All families wake up, eat, hang out at home, bathe, and go
: places. It is impossible for a family to "have no routines".
:
: R.A. McWilliam, Colorado IFSP Training, Module 1, 2004.
:.....

Children need frequent opportunities to practice skills in the places and at the times which are most relevant to growing and learning. Intervention sessions, even when provided once a week or more, are a tiny percentage of a child's time. Supporting parents and other care providers to deliver intervention throughout the day will maximize the child's learning opportunities. Research tells us that skills are best acquired, maintained and generalized when they are taught during real life activities and experiences, as opposed to "practice sessions." Families are also much less likely to implement interventions that do not fit into their everyday lives, routines and activities.

For more information on natural environments, you are encouraged to read NJ CSPD News and Information #1, "Natural Environments," and the NJEIS Service Guideline on Natural Environments in the NJEIS Resource Notebook.

.....
: "With our varied backgrounds in motor, language, or cognitive
: development, it is easy to lose sight of the big picture and isolate our
: focus on a tight muscle or a weak suck and swallow. However, when we
: remove our interventions from the natural context of development, it's
: like reading *Goodnight, Moon* without the warm snuggle."
:
: Lane, V. (n.d.) Natural environments . . . why all the fuss? Unpublished document, 2004.
:.....

The NJEIS requires that all early intervention services be provided in the natural environment, unless the child's outcomes cannot be met in a satisfactory manner in the natural environment. If it is necessary to provide services in a segregated or clinic-based setting, the provider must make a plan for how s/he will support the child and family in generalizing skills back to everyday routines, activities and places.

Relationship-Based Service Delivery

Close, loving and invested relationships are the heart and soul of the attachment between parents and children. Consistent attachment provides the child with the confidence and security that fuels his/her drive to explore the world and learn new skills.

Early intervention services and supports must always be designed in a way that promotes the critical importance of the parent and other caregivers in the child's life. Children who are experiencing delays and disabilities often have a dizzying array of medical, educational, and therapeutic professionals in their lives. Parents can easily feel as if they are often not the most important people in everyday situations. An important goal of early intervention is to help parents maintain their confidence and comfort as the leader of any team that is supporting their child.

.....
: "More" just would not have worked. We needed a different plan. We
: needed a plan that included JP as an active participant in our family- not
: the opposite."
:

: Lorna Mullis, *Natural Environments: A letter from a mother to friends, families and*
: professionals. Young Exceptional Children, 2002.
:.....

The practitioner's relationship with the parent is also of critical importance. How you interact with the parent is a mirror to how you hope the parent will be with the child. It is neither enough, nor terribly effective, to tell parents how to nurture their relationship with their child. Rather, we must demonstrate best practices through how we support and nurture family members. This is often described as a parallel process.

There will be many families whose lives will challenge your ability to be in a nurturing relationship with them. If a family perceives that you do not approve of their choices and are trying to change who they are and how they live their lives, they will surely resist your every effort. The first step in establishing a relationship is to learn to be with the family exactly where they are today.

A Note about Child Abuse and Neglect

Providing early intervention in a manner that is family-centered and relationship-based does not remove the responsibility of all early intervention practitioners to report suspected child abuse and neglect. New Jersey law (Title 9) requires that any person having reasonable cause to believe that a child has been subject to child abuse or neglect must report this information immediately to the Division of Youth and Family Services (DYFS) in the New Jersey Department of Human Services. This is referred to as a "mandated reporter". It is not acceptable to fulfill this responsibility by informing your supervisor of your suspicion so that he/she may make the report. You should consult your supervisor when making a clinical decision about whether or not the acts, concerns, and/or observations you have made constitute abuse or neglect. You must also follow the policies and procedures of your employer for this situation.

If you determine that the possibility of abuse or neglect exists, you must make the report to DYFS yourself in order to provide the best possible

first-hand information about the child and family. For more information about New Jersey and federal laws on child abuse reporting, please see the NJEIS Resource Notebook and review you agency policies and procedures.

A Final Note on Language

When we speak and write, we convey information and thoughts in direct and indirect ways. Each time we speak, we are making almost instantaneous, subconscious choices about which words to use. Everyone involved in early intervention must strive to model language that is respectful of individuals' disabilities and cultures.

.....
: "The difference between the almost right word & the right word is really a
: large matter--it's the difference between the lightning bug and the
: lightning."
:
: Mark Twain Letter to George Bainton, 10/15/1888,
: <http://www.twainquotes.com/Difference.html>, 2005.
:

"People-first" language refers to communication practices that put the person before the disability label or descriptor. People-first language focuses on the individual, not the disability. Some examples:

- ❖ "Baby with Down syndrome", rather than "Down's baby"
- ❖ "Person who uses a wheelchair", rather than "wheelchair-bound" or "confined to a wheelchair"
- ❖ "Child with autism" rather than "an autistic"

People-first language describes a condition that a person has, not what the person is. Language has a very powerful impact on how we think and feel. Using people-first language conveys the message that people with disabilities are valued as human beings and that we view their disability as only one aspect of their lives. As professionals who are involved in the lives of infants and toddlers because of their disability or delay, early intervention practitioners have an important opportunity to convey this message to the family and community at large. It is an opportunity to be a subtle but powerful agent of change.

"My son Benjamin, is 11 years old. He loves the Lone Ranger, ice cream, and playing on the computer. He has blonde hair, blue eyes, and cerebral palsy. His disability is only one piece of his life."

Kathie Snow, People First Language: A Commentary
www.state.sd.us/dhs/ddc/kathysnow.htm, 2004

Conclusion

This self-study guide has attempted to provide you with an understanding of the foundations of early intervention philosophy and practice in the New Jersey Early Intervention System. It is hoped that you will use this information and the resources included to pursue further learning and understanding about the provision of early intervention services.

Next Steps in Orientation...

Return to WWW.njeis.org to complete your self study test.

This test must be completed prior to attending the required training "Introduction to IFSP Development".

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Legal History At a Glance:

Federal

1975: Public Law (P.L.) 94-142, the Education for All Handicapped Children Act (EHA) was passed by Congress.

Requirements:

1. Appropriate public education in the least restrictive environment for all eligible school-age children.
2. Allowed services for children beginning at birth, but did not mandate such services.
3. Congress permitted the states to serve children under 5 years of age but did not order them to do it and did not provide money for the services.

1986: P.L. 99-457, Congress reauthorized EHA and added amendments:

1. Ensured preschool services to eligible 3-5 year olds - Part B.
2. Ensured early intervention services to eligible 0-3 year olds - Part H.

1991: P.L. 102-119, Congress combined the original EHA and the re-authorized law with the amendments and changed its name to IDEA - The Individuals with Disabilities Education Act.

1997: P.L. 105-17, Congress reauthorized IDEA and added amendments:

1. The Infants and Toddlers Program requirements were moved from Part H of IDEA to Part C.
2. Policies and procedures must be implemented which ensure services are provided in natural environments unless outcomes cannot be met in natural environments.

New Jersey

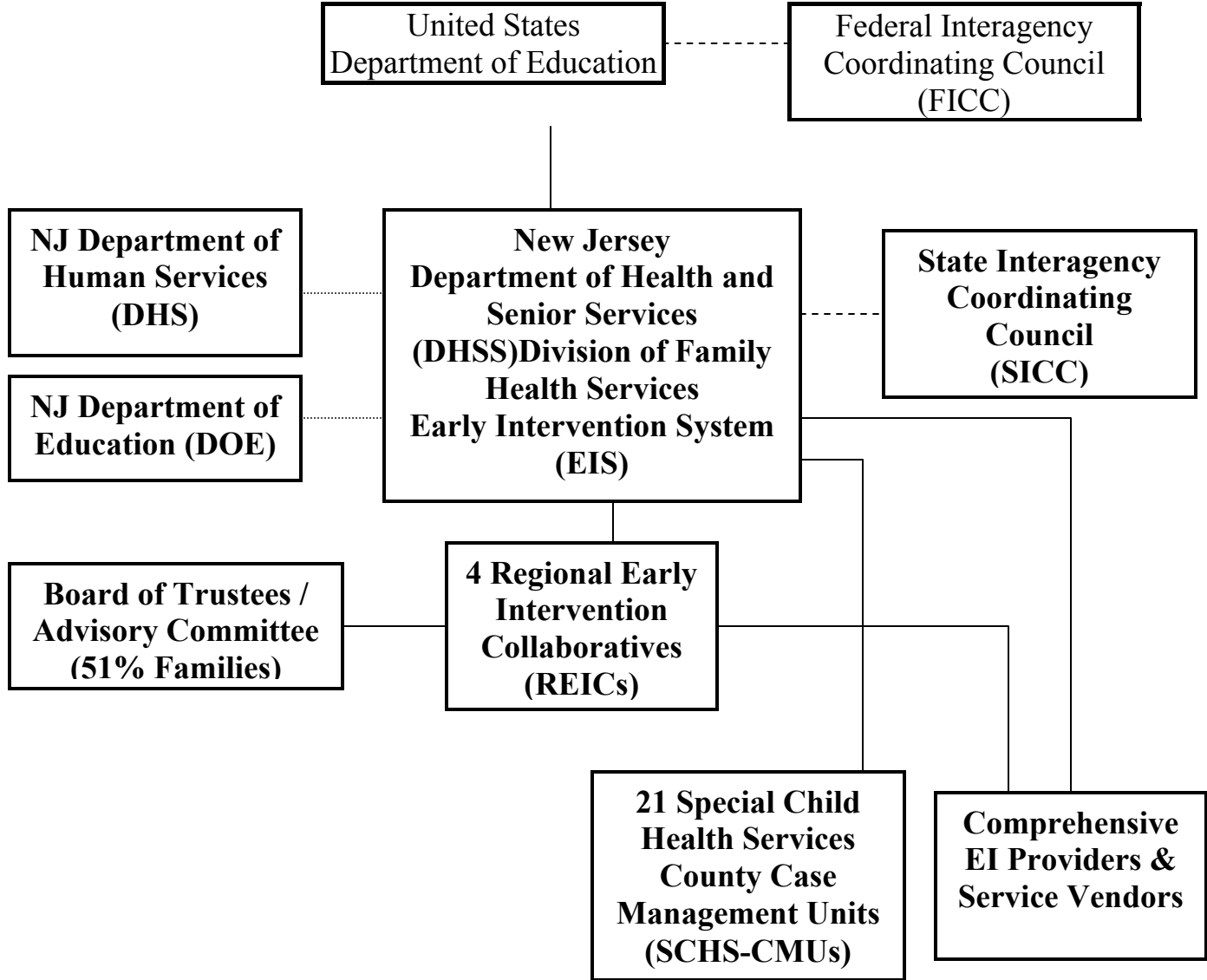
1981: Chapter 415:

1. Mandated implementation of the federal law - EHA.
2. Established the State Department of Education as the lead agency for special education.

1986: Department of Education became lead agency for the new Part H.

1992: Chapter 155 was passed which reassigned lead agency status for Part H to the State Department of Health.

EARLY INTERVENTION ORGANIZATION CHART



_____ Directly funds and/or oversees

- - - - - Advises and assists

..... Coordinates with

New Jersey Department of Health and Senior
Services (DHSS)

Commissioner
Fred M. Jacobs, M.D.

Deputy Commissioner, Public Health Services
Carolyn G. Holmes

Assistant Commissioner
Division of Family Health Services
Celeste Andriot Wood

Director
Special Child, Adult, and Early Intervention Services
Gloria M. Rodriguez

Part C Coordinator
Terry Harrison

<u>Helpful Hands</u> <u>REIC</u> Patti Ciccone <u>Counties Served:</u> Bergen, Hudson Passaic 973-256-8484	<u>Family Link</u> <u>REIC</u> Susan Marcario <u>Counties Served:</u> Essex, Morris, Sussex, Union, Warren 908-964-5303	<u>Mid-Jersey CARES</u> Cynthia Newman <u>Counties Served:</u> Hunterdon, Mercer, Ocean, Middlesex, Somerset, Monmouth 732-937-5437	<u>Southern NJ REIC</u> Jennifer Buzby <u>Counties Served:</u> Atlantic, Burlington, Camden, Cape May, Gloucester, Cumberland, Salem 856-768-6747
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Foundations of Service Provision Self-Study:
Specific Competencies Addressed

1.4 Demonstrate awareness of family and child interactions as the primary context for development and learning.

2.2 Demonstrate knowledge of state eligibility criteria and ability to interpret information to the family and team.

3.1 Demonstrate understanding of the complex job of families in caring for and providing learning opportunities for young children, and the additional responsibilities that accompany having a child with special needs.

3.2 Understand that the core of family-centered practice recognizes the family as the center of a young child's life, and is the child's constant support, decision-maker, and advocate.

3.3 Apply family-centered principles so that early intervention supports families in their task of enhancing their children's learning and development.

3.4 Respond appropriately to family strengths and individuality and respect different coping methods.

3.9 Demonstrate knowledge of the historical roots and family centered philosophy of the New Jersey Early Intervention System.

6.13 Utilize technology to access or record information and to enhance communication with families, colleagues and community members. This includes, but is not limited to, the use of; voice mail, cell phones, fax machines, computers, e-mail and the internet.

7.1 Participate as an effective team member to implement New Jersey's model of Early Intervention. Team models may include:

- ❖ multidisciplinary teams
- ❖ interdisciplinary teams
- ❖ transdisciplinary teams

8.1 Demonstrate a basic knowledge of relevant federal legislation, policies, and procedures (including IDEA, FERPA, etc...) that impact services and supports to children and families.

8.3 Demonstrate knowledge of procedural safeguard components and the ability to communicate the purpose, content, and process of each to all families served.

8.4 Demonstrate knowledge and display the ability to perform responsibilities concerning the reporting of suspected child abuse or neglect.

9.2 Demonstrate flexibility and resiliency in response to diversity and change in both families and the New Jersey Early Intervention System.

9.7 Consistently uses "people first" language, e.g. saying "a child with Down syndrome" instead of "a Down's child".