

EARLY INTERVENTION TEAM MODELS

The growing acceptance and implementation of the team approach are not solely the results of federal mandates. They also reflect early intervention professionals' view of human development that regards a child as an integrated and interactive whole, rather than as a collection of separate parts (Golin & Ducanis, 1981). The team approach also recognizes that the multifaceted problems of very young children are too complex to be addressed by a single discipline (Holm & McCartin, 1978). The complexity of developmental problems in early life (Fewell, 1983) and the interrelated nature of an infant's developmental domains are prompting early intervention specialists to recognize the need for professionals to work together as a team.

Although different team models are in use, most are composed of professionals representing a variety of disciplines: special education; social work; psychology; medicine; child development; and physical, occupational, and speech and language therapy. All teams also involve the family in varying ways and degrees. Team members share common tasks including the assessment of a child's developmental status and the development and implementation of a program plan to meet the assessed needs of the child within the context of the family.

What may best distinguish early intervention teams from one another is neither composition nor task, but rather the structure for interaction among team members. Three service delivery models that structure interaction among team members have been identified and differentiated in the literature: multidisciplinary, interdisciplinary, and transdisciplinary (Fewell, 1983; Linder, 1983; Peterson, 1987; United Cerebral Palsy National Collaborative Infant Project, 1976).

MULTIDISCIPLINARY TEAMS

On multidisciplinary teams, professionals from several disciplines work independently of each other (Fewell, 1983). Peterson (1987) compared the mode of interaction among members of multidisciplinary teams to parallel play in young children: "side by side, but separate" (p. 484). Although multidisciplinary team members may work together and share the same space and tools, they usually function quite separately.

Interaction among team members in the multidisciplinary approach does not foster services that reflect the view of the child as an integrated and interactive whole (Linder, 1983). This can lead to fragmented services for children and confusing or conflicting reports to parents.

Another concern about the multidisciplinary model is the lack of communication between team members that places the burden of coordination and case management on the family. In contrast, both the interdisciplinary and transdisciplinary approaches avoid the pitfalls of multidisciplinary service fragmentation by having the team develop a case management plan that coordinates both their services and the information that is presented to the family.

INTERDISCIPLINARY TEAMS

Interdisciplinary teams are composed of parents and professionals from several disciplines. The difference between multidisciplinary and interdisciplinary teams lies in the interaction among

team members. Interdisciplinary teams are characterized by formal channels of communication that encourage team members to share their information and discuss individual results (Fewell, 1983; Peterson, 1987). Regular meetings are usually scheduled to discuss shared cases.

Representatives of various professional disciplines separately assess children and families, but the team does come together at some point to discuss the results of their individual assessment and to develop plans for intervention. Generally, each specialist is responsible for the part of the service plan related to his or her professional discipline.

Although this approach solves some of the problems associated with multidisciplinary teams, communication and interaction problems (e.g., influence of "professional turf") may impinge upon the team process.

TRANSDISCIPLINARY TEAMS

Transdisciplinary teams are also composed of parents and professionals from several disciplines. The transdisciplinary approach attempts to overcome the confines of individual disciplines in order to form a team that crosses and recrosses disciplinary boundaries and thereby maximizes communication, interaction, and cooperation among team members.

Fundamental to this model are two beliefs: (1) children's development must be viewed as integrated and interactive, and (2) children must be served within the context of the family. Since they have the greatest influence on their children's development, families are seen as a very critical part of the transdisciplinary team and are involved in setting goals and making programmatic decisions for themselves and their children. All decisions in the areas of assessment and program planning, implementation, and evaluation are made by team consensus. Although all team members share responsibility for the development of the service plan, it is carried out by the family and one other team member who is designated as the primary service provider.

Another characteristic of a transdisciplinary team is that team members accept and accentuate each other's knowledge and strengths to benefit the team, the child, and the family (Lyon & Lyon, 1980). Staff development in the form of mutual training may occur at three increasing levels of complexity: (1) sharing general information; (2) teaching others to make specific judgments; and (3) teaching others to perform specific actions. The first two levels pertain to the sharing of information while the third level pertains to the sharing of roles.

IMPLICATIONS OF THE TRANSDISCIPLINARY MODEL FOR STAFF

Because transdisciplinary team members are interdependent, all must commit themselves to assist and support one another. This commitment is demonstrated by the following behaviors:

- (1) Giving the time and energy necessary to teach, learn, and work across traditional disciplinary boundaries.

(2) Working toward making all decisions about the child and family by team consensus--that is, giving up disciplinary control.

(3) Supporting the family and one other team member as the child's primary service provider.

(4) Recognizing the family as the most important influence in the child's life and including them as equal team members who have a say in all decisions about the child's program.

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