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Coaching Model in Early Intervention: An Introduction

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Coaching is an interactive process between caregiver and practitioner that provides support and encouragement, develops new skills, and promotes self-assessment and learning. The coach's goal is for the learner to have the competence and confidence to engage in self-reflection, self-correction, and generalization of new skills and strategies to other situations as appropriate. The ultimate goal is to promote care provider competence and confidence to support the child's participation and learning for life roles (Hanft, Rush, & Shelden, 2003).

Many states have implemented or are implementing this model in early intervention practice, with varying interpretations of the model and varying degrees of success. Some states are presenting this model as being the only "evidence-based" approach. This article presents an overview of the model as it is being interpreted in a variety of states, discusses issues encountered, and outlines conditions for success.

Introduction

With the passage of the Education for All Handicapped Children Amendments Act of 1986 (Public Law 99-457), states have been allowed to determine the lead agency of service coordination and the methods of early intervention service delivery for infants and toddlers (SRI International, n.d.). Across the country, multiple models and systems for intervention were developed. However, instead of drafting new systems from the ground up, many states either accepted or added onto existing case management systems (Gomm, 2006). Lately, some states have begun to revise their plans for intervention from a direct service to the child orientation to a more family-centered and focused orientation. As experts in the field have recently pointed out, "The early intervention field

has a responsibility to examine continually the consequences of its systems for children and their families, and to use this information subsequently to improve early intervention policies and practices" (Dunst & Bruder, 2006, p. 163).

Dunst and Bruder (2006) categorized and described three major approaches to service coordination models: (a) dedicated and independent, (b) dedicated but not independent, and (c) blended. The dedicated and independent model is structured so that the interventionist only coordinates services, while the agency providing the coordination is independent (as in Kentucky). In the dedicated but not independent model, the service coordinator only provides service coordination while working for the agency responsible for providing the intervention (as in Georgia). In the blended model, the interventionist provides both intervention services and service coordination (as in South Carolina). Dunst and Bruder cite a study which found that most states (47%) used a combination of models, a smaller percentage (27%) used a dedicated model, and fewer (26%) used a model that could not be described as dedicated. Some researchers assert that the attention states and local intervention systems give to service coordination is not what it merits (Bruder & Dunst, 2006).

The blended model is akin to the primary service provider (PSP) model. The premise of the PSP is that early intervention can be most effective when the family develops a solid rapport with one lead provider who has the unconditional support from the entire team (Gomm, 2006). This approach has been described as transdisciplinary. The services support and enhance the family's ability to meet the individual needs of the children. Members of the team play different roles, and in general, one team member provides direct services and support to the child's family and child care providers (*Early intervention*

for infants and toddlers, 1989). Roles are shared, and therapists and educators assist team members to acquire skills to enable the PSP to be proficient in their varied expertise. Many states have implemented or are implementing the PSP model in early intervention practice, with varying interpretations of the model and varying degrees of success. In some states, therapists are embracing the model; whereas in others, they are resisting it on ethical and emotional grounds. Some states are presenting this model as being the only *evidence-based* approach, primarily because so little published research supports the outcomes of direct therapy in early intervention.

Two major shifts in early intervention service have been occurring. One shift is to provide intervention within the context of daily schedules, activities, and spaces. The second shift is from expert driven to learner focused services (Coaching in Early Childhood, n.d). The primary coach model is one particular interpretation of the transdisciplinary or PSP model that is based on both of these changes.

Operational Definition of Coaching

As mentioned earlier, coaching is an interactive process between caregiver and practitioner that provides support and encouragement, develops new skills, and promotes self-assessment and learning. The coach promotes care provider competence and confidence in supporting the child's participation and learning for life roles. The coach enables the learner to engage in self-reflection, self-correction, and generalization of new skills and strategies to other situations, as appropriate, competently and confidently (Hanft et al., 2003). Coaching differs from consultation in attitude: Coaching is family centered and family driven, as opposed to traditional consultation that tends to be professionally centered and driven. In addition, under the coaching model, the whole view of the child and family are more positive and strengths based, as opposed to deficit based. The primary coach approach supports families of young children with disabilities by identifying one multidisciplinary team

member as the PSP. The PSP receives coaching from other team members as well as uses coaching as the key intervention strategy to build parents' and other care providers' capacity to use everyday learning opportunities to promote child development (Rush & Shelden, 2005).

Promoting care provider competence and confidence is necessary to supporting the child's participation and learning for life roles. The PSP, with support from other team members, uses coaching as the primary intervention strategy to implement jointly developed, functional, and discipline-free individualized family service program and individualized education program outcomes that promote increased child learning and participation in real-life activity settings. The primary coach or PSP is selected based on expertise in child development, family support, and coaching. As well, the team has a variety of knowledge, skills, and experiences to provide to the primary coach. Reciprocal coaching and learning, then, occur between the primary coach and care providers and between the primary coach and other team members.

The primary coach receives coaching through ongoing interactions, particularly joint visits. The purpose of visits that occur separately from those with care providers is for the primary coach to gain information to continue his or her work with the family. Ongoing interaction provides opportunities for reflection and information sharing. Team members' coaching to the primary coach may vary, depending on the need or desire for timely ideas and feedback.

According to Rush, Shelden, and Hanft (2003):

Coaching has been shown to help interventionists provide effective services by: sustaining their efforts to use new skills or integrate new knowledge; reducing isolation and facilitating exchange of ideas, methods, experiences, and resources; promoting development of trust and collegial family-provider relationships; and encouraging providers and families to engage in continual learning. (p. 3)

The Nebraska Departments of Education and Health and Human Services (2002) concur: "Learner-focused intervention is a concept that moves the focus of the intervention off the child with the disability and emphasizes supporting those people involved with the child across a variety of environments" (p. 1). Furthermore, according to this same source, "Selecting the Primary Service Provider as coach involves identifying the key interventionist who has the needed expertise at the critical time" (p. 2).

Interestingly, Dunst, Brookfield, and Epstein (1998) found that the overall extent of child and family services provided is related negatively to personal and family unit well-being. According to these authors, as the amount of services increases, the family functions less well. In another study, Dunst and Bruder (2002) found that parent satisfaction with providers showed an inverse ratio of degree of satisfaction with number of providers. The fragmentation of services can put families at risk because this

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usually means that the focus is on a deficit model rather than on a wellness model.

Conditions for Success

Much has been written about the conditions necessary for this model to succeed. Although these conditions may seem challenging, they are attainable and required for success. First, the PSP must work in close partnership with the family and the team. The PSP must be willing to share expertise as well as to assimilate the expertise of the others on the team. As for the family, learning occurs in the milieu of relationships; everyone in the child's life, including household pets, can influence the child's progress (Pilkington, 2006). As for the team, the partnership includes the family and the sharing of practices to make everyone more competent in their intervention practices through the team's unique assets.

A second component for successful implementation of the transdisciplinary model involves the need for the other team members to provide the essential consultation to support the primary coach in a *timely manner*. This is necessary because of each child's special situation and the rate at which progress is being made. As new skills emerge, or when they do not progress as expected, the team's collective insight and knowledge can make a difference as it creates plans opportune to addressing the child's needs. Additionally, the parent or care provider may need ongoing feedback in order to be confident that the interactions they offer are appropriate (Nebraska Departments of Education and Health and Human Services, 2002).

A third condition requires the other team members to either participate in joint visits or provide strategies and techniques that will ultimately enhance the child's progress (Infant & Toddler Connection of Virginia, 2003). As Pilkington (2006) suggested, "Coaching is also performance based, assisting individual learners (a family member, caregiver, or colleague) to acquire and refine desired skills and knowledge" (p. 13). Within this context, the team must continually review the process and the child's progress and then adjust the process if the effectiveness is determined to be less than optimal.

The fourth requirement involves individualization of both the frequency in which services are offered and the determination of the PSP based on the child's and the family's distinctive concerns, desires, competence, talents, resources, main priorities, and targeted end results (Infant & Toddler Connection of Virginia, 2003). The coaching paradigm promotes a relationship-based model that posits that early intervention is more effective if the interventionist and family form a solid and positive relationship (Gomm, 2006). The implication is that good relationships generally are built on an appreciation of the concerns, desires, competence, talents, and priorities of all. A good relationship between the family and interventionist is crucial to the success of this prototype. Some

states are promoting this method because it strengthens the competence and confidence of the family and builds on what the family knows and sees as priorities (Oregon Department of Education, 2002).

A fifth requirement for success is that the coaching model must be collaborative, insightful, and reciprocal (Pilkington, 2006). Team members must accept and accentuate one another's knowledge and strength to benefit the team, the child, and the family. This concept is not new. What currently is emphasized is the positive focus and elevation of the family from passive receiver of services to active director of the child's participation.

The final requirement for success involves each interventionist's caseload. The caseload must be achievable if effective services are to be delivered (Gomm, 2006). The team needs time to share information and skills and to learn new skills in order to cross disciplinary limitations. Therefore, it is essential that the team have unequivocal support from all administrators involved (Coaching in Early Childhood, n.d.).

Conclusion

Coaching can provide an excellent structure for encouraging discussions among the family, care providers, and early interventionists to choose and execute effective strategies to achieve the targeted outcomes. Research indicates that coaching has many positive outcomes. One cautionary note: Implementing the coaching paradigm should be viewed as a process likened to a developmental continuum. The process begins with an awareness of the model followed by an examination and exploration of the process. It is necessary for therapists to proceed through these levels before they reach the level of use and implementation. As noted throughout this article, more and more research has emerged in support of the coaching model. It behooves the therapist to consider seriously this model as a workable and effective approach to early intervention. The model also can be a rallying call for concerted research into the practice of occupational therapy within early intervention practice. ■

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