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Providing Early Intervention Within Natural Environments

A Cross-cultural Comparison

Anja Rantala, PhD; Sanna Uotinen, MEd; R. A. McWilliam, PhD

The purposes of this study were to determine the state of current practice in early intervention in Finland and to compare them to American data. Professional women ($N = 52$), representing child care, elementary school, healthcare, and social work, completed the Families in Natural Environments Scale of Service Evaluation, a 34-item questionnaire about typical and ideal practices. Large differences between typical and ideal practices were found in all the 4 components of early intervention measured: first encounters, intervention planning, functionality, and service delivery. American typical-practice scores were more family-centered and in natural environments than Finnish scores, but some Finnish ideal-practice scores were higher than American scores. Implications for national administration of early intervention services, outcomes research, and more in-depth research are discussed. **Key words:** *early intervention*, *family-centered practice*, *natural environment*, *typical and ideal practices*

FINLAND has a system of supports in place for young children at risk for developmental delay. This system consists of approximately 3000 child care centers, most under public administration. In addition to child care, early intervention is provided by many other organizers, which might make it difficult for parents to discern the wholeness (European Agency for Development in Special Needs Education, 2003). Central Union for Child Welfare in Finland (2006) has summarized services provided by society to a child with special needs and his family. These services are healthcare, child welfare clinic, social insurance institution, social work, school system, and some other authorities. Children can also receive therapy services in private practices if families choose to augment what is available in the public programs (European Agency for Development in Special Needs Education, 2003). Rantala (2002) categorized early intervention services on the basis of professionals' work and came up with 4 main groups: child care, child welfare clinic, social work, and therapy. Children with special needs often attend child care centers. They can be enrolled in a group for typically developing children (approximately 20 children in a group) or in an integrated group for both children with special needs and typically developing children (approximately 12 children in a group) or in a special group for children with special needs (approximately 8 children in a group). The first group is taught by generic early childhood teacher (ECT) and supported by itinerant early childhood special teacher (ECST), but the 2 latter groups are taught by ECST. Most commonly, children with special needs participate in a group for typically developing children, partly because

***Author Affiliations:** Department of Educational Sciences, Special Education, University of Jyväskylä, Jyväskylä, Finland (Dr Rantala); University of Jyväskylä, Open University, Jyväskylä, Finland (Ms Uotinen); and Siskin Children's Institute, Chattanooga, Tennessee (Dr McWilliam).*

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***Corresponding Author:** Anja Rantala, PhD, Department of Educational Sciences/Special Education. PO Box 35 (Viveca) FI-40014 University of Jyväskylä, Finland.*

special groups are not only available in larger cities, but also because of the current trend toward inclusion (Kovanen, 2002; Viitala, 2000, p. 81). Only 6% of children with special needs participate in special group program (Viitala, 2000, p. 82).

The Act on Child Day Care requires that a written individual educational plan (IEP) or individual early childhood education and care plan (as stated in National Curriculum Guidelines on Early Childhood Education and Care in Finland, 2003) is established by child care center for every child with special needs. Rehabilitation plans, prepared by health services, are utilized, when planning IEP. It is also stated that IEP should be written in collaboration with parents and other professionals involved in child rehabilitation. Teachers (ECT/ECST) are highly qualified, and they have a philosophy that emphasizes the collaboration with parents (European Agency for Development in Special Needs Education, 2003; Kovanen, 2001). Family centeredness, which refers to a combination of beliefs, values, and practices for supporting and strengthening family capacity to promote child development and learning (Dunst, 2002), is the orientation in Finnish early intervention and professionals are committed to develop that (Kovanen, 2001). However, early intervention also has characteristics of professional-centered and sector-based practices (Rantala 2002, p. 192). Finnish legislation does not specifically provide guidelines for parents' participations and also early intervention professionals are mainly trained to work as experts in their disciplines (Kovanen, 2001).

The purposes of this study were to determine the state of current practice in Finland and to compare them to American data. This comparison might help us understand the value of a measurement tool for evaluating early intervention services. We begin with a discussion of major assumptions underlying measurement of the quality of early intervention. These assumptions are derived from a principal components analysis of the Families in Natural Environments Scale of Service Evaluation (FINESSE; McWilliam, 2000), which is described later in the "Methods" section.

BACKGROUND

Describing early intervention

Working with families has always been an important part of early intervention and it is emphasized that one of the main focus should be in supporting the whole family (Bailey et al., 1998; Bailey, Buysse, Edmondson, & Smith, 1992). Families do not typically learn about early intervention until they need to, so one of the roles of the professionals is to give families information about early intervention, including how services work. Research on the impact of first contacts is lacking, but one can anticipate that the family's first exposure to the materials and professionals in early intervention help set their expectations. Therefore, if the program is described primarily in terms of child-related issues and in terms of services, families are likely to think that early intervention is about providing *services* for *children*, rather than about providing *support* for *families*. The materials, initial telephone contacts, and intake visit can all reveal whether a program has a philosophy more aligned with rehabilitation, deficits, and a medical approach or with prevention, assets, and educational philosophy. Dunst, Johanson, Trivette, and Hamby (1991) have shown how the terms programs use to describe themselves (eg, "family centered") can be unreliable and that there are ways to discern programs' true orientations. The description of early intervention is, therefore, an important issue in implementation.

Planning interventions

The backbone of early intervention services is the plan about what to do with the child and family. Preferably, there should be one plan that summarizes needs, resources, concerns, priorities, outcomes (goals), and services to meet those goals. Assessment of child functioning is done in early intervention for multiple purposes, such as determining eligibility,

determining functional needs, and determining reasons for problems in function. Historically, perhaps owing to a psychological tradition in early intervention, assessment has been focused on standardized testing, even though the limitations of such assessment have long been remarked upon (eg, Dunst & McWilliam, 1988). Vehkakoski (2003) highlights in her study that in reports, written by professionals, the typical practice was to pay attention to the child's developmental deficiencies and use normative criteria compatible with age as the basis for assessments.

With respect to natural environments, the main challenge in assessment is to capture functional needs, which are often overlooked when professionals go from testing for eligibility determination straight to the development of goals. Obviously, test results are decontextualized and have nothing to do with the routines of everyday life (Bagnato, 2006; Bronfenbrenner, 1986; Gallimore, Weisner, Kaufman, & Bernheimer, 1989). The way interventions are planned, therefore, reveals a philosophy of deficits, which tests are designed to identify, versus needs in routines, which have to be identified by the adults, who are in those routines (ie, parents, teachers).

Integrating interventions

Once needs are identified, services must be organized. A number of models of service delivery have evolved in early intervention. Two dimensions can be considered: the setting and the extent to which the child or adult is the focus, as shown in Figure 1. For example, children receiving therapy in a clinic get services in the least natural environment, whereas families receiving support in the home get services in the most natural environment. The 2 axes reflect the fact that the focus can be at different places along that continuum, regardless of setting. For the most part, however, there is usually an association between naturalness of setting and focus of the service. The goal is to support families in enhancing their children's development. Because they already do provide their children with learning opportunities in natural environments, such as the home, family child care homes, and child care programs, these are the environments where services should be provided (Dunst, Hamby, Trivette, Raab, & Bruder, 2000). In assessing the quality of early intervention, therefore, it should be determined who does the actual interventions with the child (professionals or natural caregivers), where (in

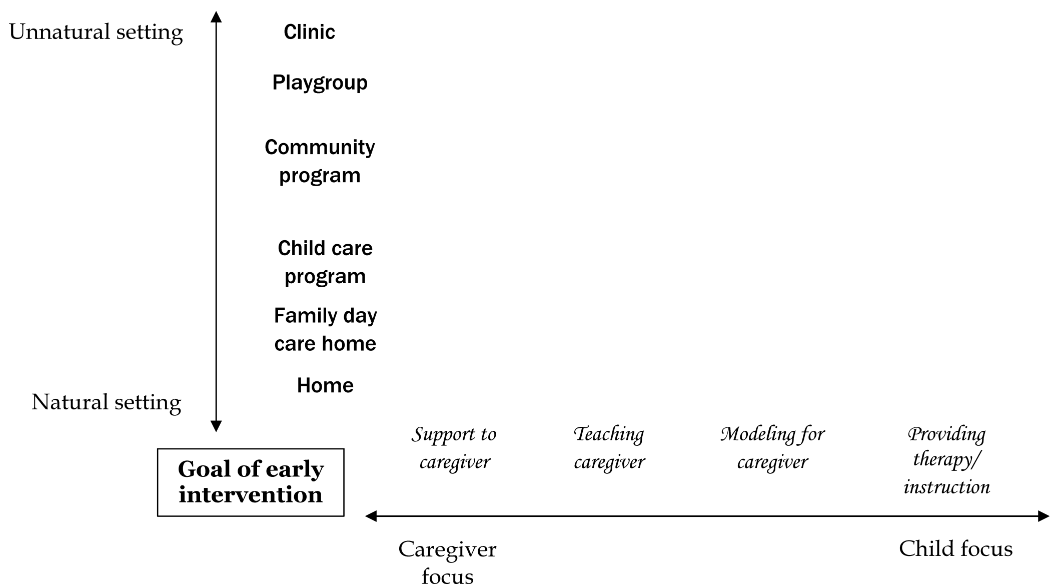

Figure 1. Setting and adult versus child focus as service delivery dimensions.

unnatural or natural settings), and when (on the professional's timetable or when the child is interested and the caregivers are able). Determining those factors reveals a belief about how children learn. If early intervention is viewed as direct, hands-on work by professionals, especially in unnatural settings, presumably the belief is that children can learn in isolated lessons or sessions and transfer the skills to other people, times, and places. On the other hand, if early intervention is viewed as support to natural caregivers, especially in discussion about their natural routines, presumably the belief is that children learn best throughout the day, in "dispersed trials," with the natural stimuli for the desired behaviors.

Consulting

The role of the professional has been discussed in the previous section on implementation of interventions. This is important to determine when assessing the quality of early intervention. If a consultative role is expected, professionals must be able to work successfully with adults, not just children. In working with adults in the context of early intervention, professionals need to follow principles of social support (Davis & Rushton, 1991; Dunst, 1990; Dunst, Trivette, & Hamby, 1996; McCubbin, Cauble, & Patterson, 1982), help giving (Brickman et al., 1983; Brickman, Rabinowitz, Karuza, Cohn, & Kidder, 1982; Dunst, Trivette, Davis, & Cornwell, 1994; Michlitsch & Frankel, 1989), and adult education (Knowles, Holton, & Swanson, 1998; Merriam & Caffarella, 1999).

Evaluating the quality of early intervention

Little research involving the measurement of early intervention quality has been done. In his work on the evaluation of early intervention programs from an international perspective, Mitchell (1993) has conceived of 6 principal values: community coherence, cultural sensitivity, right to services, family integrity, professional standards, and accountability. Results have not been retrievable from this scale. Because of the dearth of measures of early intervention quality, measures of associated quality indices were explored. One such index is family-centered practice. R. A. McWilliam, Snyder, Harbin, Porter, and Munn (2000) found that professionals reported more family-centered typical practice than did families, but ideal practices generally did not vary between parents and professionals. They also found that professionals' reporting implementation of family-centered practices were more likely to be providers of home-based services than to be service coordinators only or providers of clinic-based services. As for families' reports, the longer they had been in early intervention, the more frequently they experienced family-centered practices. Despite the current preoccupation with the outcomes of early intervention (Bailey et al., 2006; Hebbeler, 2005), little attention has been paid to measurement of the quality of early intervention. One preliminary study (R. A. McWilliam & Er, 2003) was, however, conducted in 6 countries, involving an instrument called the FINESSE (McWilliam, 2000). With this instrument, using a nonrepresentative sample, it appeared that the highest quality was found in Portugal, followed by Spain, and the lowest quality was found in Turkey, followed by the United States. Israel and Greece scored in the middle. This international research suggested that providing services in natural environments is appropriate and practiced internationally and that the FINESSE is useful for developing a profile of a program or a country. Across countries, programs showed strengths in family-centered, functional intakes, identifying family needs, explicitly stating the purpose of goals, and using equipment sensibly. Programs showed weaknesses in family-centered written program descriptions, family-centered goal selection, identifying family goals, embedding interventions in routines, believing that intervention should support the family, focusing interventions on routines, and using collaborative consultation with child care. One purpose of the current study was to determine the state of the field in Finland.

METHODS

Participants

A total of 52 professional women in Finland, representing child care, elementary school, healthcare, and social work, participated in the study. Consequently, the professionals worked with children and families in different sectors in the Finnish early intervention organization. The participants were kindergarten teachers, special teachers, public health nurses, and social workers.

The participants worked in both small and large communities and most of them had a wide range of experience in their field. The participants were well representing the Finnish professionals in social and healthcare on the grounds of gender, period of employment, and residence. One participant worked in more than 1 community, which is common in the sparsely inhabited areas in Finland. The background information of the participants has been described in Table 1.

Instrumentation

The FINESSE (McWilliam, 2000) was used. This questionnaire asks professionals to rate their typical and ideal practices for providing services in early intervention. The questionnaire consists of 17 items, which are made up of 4 different factors: first encounters, intervention planning, functionality, and service delivery (R. A. McWilliam, Rasmussen, & Snyder, 2007). The items are rated on a 7-point scale with anchors at the odd-numbered items. Practices inconsistent with serving families in natural environments or otherwise in a high-quality manner correspond to the lowest-score marker. Two ratings are given for each item. The first rating represents the typical practice of the respondent, or what he or she does now, and the second rating represents the ideal practice, or what he or she would like to do. The questionnaire also includes one open-ended question, in which the respondent is asked to consider the factors contributing to the discrepancy between typical and ideal practices.

Table 1. Respondents' characteristics

	%	*N*
Field of employment		
Day care	44.2	23
Elementary school	21.2	11
Healthcare	26.9	14
Social work	7.7	4
Experience, y		
Less than 5	30.8	16
5–20	55.8	29
More than 20	13.5	7
Size of community		
Less than 5000 people	13.5	7
5000–20 000 people	28.8	15
20 000–40 000 people	25.0	13
More than 40 000 people	30.8	16

Procedures

Participants in 2 multidisciplinary refresher courses for education, social, and healthcare professionals were asked to complete the FINESSE in the beginning of the course. The courses were directed to the professionals in early intervention, and they involved many of the areas of working with families. The courses were voluntary to the participants. These courses were held in spring 2005. Participants were asked to complete the FINESSE according to the specified directions. Some items on the FINESSE were not part of every respondent's job. If an item described something that was not part of the respondent's job, she was asked to respond using her best knowledge of the practice.

Data analysis

For typical and ideal scores, means were compared, using effect sizes (Cohen's d) and paired-sample t tests to determine the level of statistical significance for the differences. Means in the Finnish and American data were compared for the typical and ideal scores as well as the difference between typical and ideal scores.

The open questions of the questionnaire were analyzed by using the theme analyze

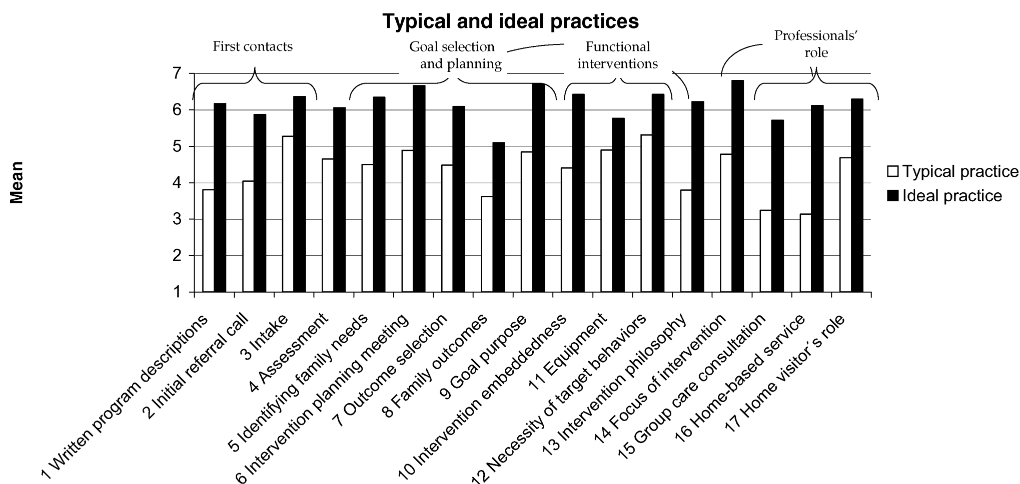

Figure 2. Mean typical- and ideal-practice scores.

method. Citations in the "Results" section are picked out from open question answers or from the notes written next to the items. When referred to a citation, the occupation of the respondent is also presented.

RESULTS

Ratings of typical and ideal practices

Large differences between typical and ideal practices were found in all the 17 items (see Fig 2). Cohen's d ranged from 0.75 to 2.46, and all paired-samples t tests resulted in $P < .0001$. The following results are organized by groupings of items into factors found in a US sample of more than 400 participants (R. A. McWilliam et al., 2007).

First encounters

The initial interactions between parents and professionals were addressed in items 1 through 3 (Fig 2), which described the intake process, referral call, and the program's written materials. Scores for typical practices on item 1 showed that written materials emphasized services for the child only, such as therapy. None of the respondents' typical practices emphasized emotional, informational, and material support for the whole family. However, this was the ideal practice for 40.4% of the respondents. Eleven people did not indicate their typical practices. Those who did not answer wrote the following: we *don't have any written material* (TBS), *we don't deliver written material* (ECST), *there is no mention about these in child care brochures*, *I haven't seen brochures like that* (ECT), or *it is not part of my duty* (nurse).*

As indicated by the scores for item 2, the initial referral call with a family focused on describing the program primarily in terms of intervention for the child and mentioned support to families. Only 3 respondents (5.7%) reported that the initial referral call focused on providing support to families (score of 7). Focusing primarily on supporting the family was the ideal practice of 32.7% of the respondents. Scores on item 3 indicated that, during intake, primarily services for the child were described. More than half of the respondents (57%) indicated that getting to know the family and answering their questions would be the ideal practice during intake.

Intervention planning

Items in this factor, numbers 4 through 8 and 14, described the selection of goals and intervention planning (see Fig 2). For assessment of intervention planning, 37% of

*TBS indicates teacher in basic school.

the respondents indicated that standardized instruments that focus on traditional developmental domains were used, although only 5.8% of the respondents thought this was the ideal practice. Using a routines-based interview that focuses on family functioning, child engagement and social relationships were indicated as an ideal practice by 40.4% of the respondents, but a typical practice for only 7.7% of the respondents. Scores showed that outcomes and goals were selected from tests, curricula, checklists, and professionals' recommendations by 32.7% of the respondents. Outcomes/goals were typically selected from family concerns, according to 28.8% of the respondents, and 76.9% of the respondents said that this was the ideal practice.

According to 88.5% of the respondents, the focus of interventions and outcomes should ideally be routines-based (not discipline specific); 28.8% considered this to be typical practice. Few (9.8%) said that the typical focus of interventions and outcomes were discipline specific. Most reported that interventions and outcomes were context-specific but not routine-based (score of 5).

For item 6, half (50%) of the typical responses indicated that during planning meetings they discuss child and family needs and functional intervention strategies and parents are actively involved in the discussion, whereas no respondents indicated that professionals primarily discuss test scores and services offered by the program and parents listen. One of the respondents reported that *it depends on family how the conversation goes* (ECST). A planning meeting in which parents discuss routines, priorities, and concerns, while professionals ask questions and listen, was seen as the ideal practice for 69.2%. This was typical practice for only 9.6%. For item 5, regular, monthly conversations with families about families' aspirations was seen as an ideal practice for identifying family needs for 53.8%, whereas 5.8% said that this was the typical practice.

Seventy percent of the respondents stated that in their typical practices only child-related family outcomes/goals are included in the individual family service plan (IFSP) (item 8). Family goals unrelated to the child are included in the IFSP by only 1.9%, and only 7.7% considered this to be the ideal practice. This item had the lowest-mean ideal score (5.1) in the whole FINESSE.

In item 9, the purpose for each outcome or goal is not clear in the IFSP as the typical practice for only 2 (3.8%) of the respondents, whereas 17.3% of the respondents said that goals are stated explicitly. This was the ideal practice for 86.5% of the respondents. One reason indicated for unclear outcomes was that *at the moment the practice is diverse and there is a need for a coherent form or plan* (ECST). For 1 respondent, the term *IFSP* was a strange concept. She stated that *the term is not used with us. On the other hand, I have a bad conscience, since as an early childhood special educator, I should be the one developing this in our community, but I am too tired to always develop, and part of the work goes down the drain since everything is so scattered in the field* (ECST).

Functionality

Items 10 through 12 are related to the functionality of interventions and how they are integrated into daily life (see Fig 2). Scores on the embeddedness of interventions suggest that professionals typically require families to set aside specific times for intervention. Some professionals said that activities involved significant modifications of existing routines by families, 17.3% of the respondents reported that activities involve minor modifications of existing routines. This, however, was the ideal practice for 65.4% of the respondents.

On item 11, only 7.7% of the respondents indicated that much specialized equipment is used even when it is not necessary for successful functioning in everyday routines. Half of the respondents said that equipment designed to facilitate future development and prevent problems was used, yet only 5.8% said that only specialized equipment necessary for successful functioning in everyday routines was used. This last opinion was considered ideal practice by 19.2% of the respondents.

Recommending target behaviors necessary for functioning in current routines was the typical practice of 30.8% of the respondents. Almost half of the respondents (46.2%) considered this to be an ideal practice. None of the respondents said that they recommend target behaviors only indirectly related to functioning in routines.

Service delivery

The role of professionals in home- and center-based services is described in items 13 and 15 through 17 (see Fig 2). A few of the respondents did not answer question 15 because it was not part of their job, and a few said that consultative professionals worked in their group all the time. One respondent pointed out that *methods varied depending on child* (ECT). It was also said that *it takes most of the time consulting the staff and having meetings concerning the child. Consultative early childhood special educator has nowadays no time to have small group for children* (ECST). The ideal practice, according to 44.2% of the respondents, when consulting in classrooms, was to use individualized activities within routines, yet this was the typical practice for only 11.5%.

Item 16 was not answered by all of the respondents as well, because it described home-based services. They responded that *it is not part of my job* (ECT), *only social workers practice home visits* (ECST), *only a child with mental retardation has a speech therapist, or occupational therapist etc. visiting home* (ECST). When home visits were made, the typical practice was interdisciplinary home visits, where professionals provide regular visits and exchange information occasionally. Pure transdisciplinary, where any team member provides regular home visits and receives consultation from other professionals, was considered by 44.2% of the respondents to be the ideal practice. None of the respondents, however, considered this to be the typical practice. Home visits were not considered necessary by every respondent as the following comment points out: *guidance is taken place somewhere else than child's home, do we need home visits* (ECT).

Item 17, regarding the home visitor's primary role, was also not completed by a number of respondents. Of those who did respond, 42.3% stated that their ideal practice was to provide material, informational, and emotional support by talking with families and 9.6% said that this was their typical practice.

Scores on item 13, intervention philosophy, indicated that the most typical practice (40.4%) was to provide education and therapy for children. This was, however, the ideal practice for only 3.8% of the respondents. Instead, more than half of the respondents (59.6%) said that their ideal practice was to support the family, yet only 13.5% considered this to be typical practice.

Differences between Finnish and American scores

The FINESSE has been used to compare early intervention in different countries (R. A. McWilliam & Er, 2003). The current data were compared with those from a study of more than 400 participants in the United States (R. A. McWilliam et al., 2007). Effect sizes show differences between Finnish and American scores on both typical and ideal practices (see Table 2). Most differences are small to moderate, but items 1 (written program descriptions), 10 (intervention embeddedness), and 11 (equipment) show large differences in *typical* scores, with American scores higher. On 7 items, no noteworthy differences were found in typical practices. In a number of items, Finnish respondents gave higher ratings for ideal practice than did American respondents, most notably in items 17 (home visitor's role), 14 (focus of intervention), and 16 (home-based model). American respondents had higher ideal-practice ratings for 4 items, most notably items 11 (equipment) and 8 (family outcomes/goals).

The average scores for the 4 factors also showed some differences between American and Finnish reported practices. American mean scores for their typical practices in

Table 2. Finnish and American mean scores for typical and ideal practices, with size of differences for each FINESSE item

Item	***M* (Fin)**	***M* (US)**	***SD* (Fin)**	***SD* (US)**	***N* (Fin)**	***N* (US)**	***d***
Written program descriptions							
Q1 T	3.81	5.22	1.52	1.16	41	492	1.04
Q1 I	6.20	6.02	0.872	1.06		449	−0.19
Initial referral call							
Q2 T	4.04	4.76	1.64	1.26	48	492	0.49
Q2 I	5.88	5.92	1.27	1.06		413	0.03
Intake							
Q3 T	5.28	5.24	1.18	1.11	51	492	−0.03
Q3 I	6.35	6.20	0.844	0.930		400	−0.17
Intervention planning assessment							
Q4 T	4.65	4.11	1.33	1.62	49	492	−0.36
Q4 I	6.04	5.82	1.02	1.19		436	−0.20
Identifying family needs							
Q5 T	4.50	5.79	1.39	1.34	52	492	0.94
Q5 I	6.35	6.62	0.814	0.826		448	0.33
Intervention planning meetings							
Q6 T	4.89	5.04	1.11	1.22	51	492	0.13
Q6 I	6.67	6.36	0.554	0.794		441	−0.45
Outcome/goal selection							
Q7 T	4.48	4.72	1.73	1.16	52	492	0.16
Q7 I	6.10	6.04	1.11	1.02		443	−0.06
Family outcomes/goals							
Q8 T	3.62	4.52	1.28	1.57	50	492	0.63
Q8 I	5.10	5.76	1.05	1.13		437	0.61
Outcome/goal purpose							
Q9 T	4.85	5.53	1.55	1.33	52	492	0.47
Q9 I	6.71	6.70	0.893	0.703		441	−0.01
Intervention embeddedness							
Q10 T	4.40	6.00	1.73	1.24	52	492	1.06
Q10 I	6.42	6.69	1.05	0.678		442	0.31
Equipment							
Q11 T	4.85	5.74	1.07	1.10	48	492	0.82
Q11 I	5.77	6.36	0.778	0.890		432	0.71
Target behavior necessity							
Q12 T	5.32	5.41	1.51	1.13	47	492	0.07
Q12 I	6.43	6.45	0.684	0.798		418	0.03
Intervention philosophy							
Q13 T	3.80	4.74	2.32	1.46	52	492	0.48
Q13 I	6.23	5.80	1.29	1.12		441	−0.36
Focus of intervention							
Q14 T	4.78	4.88	1.90	1.52	51	492	0.06
Q14 I	6.80	6.29	0.722	1.10		437	−0.55

(*continues*)

Table 2. Finnish and American mean scores for typical and ideal practices, with size of differences for each FINESSE item (*Continued*)

Item	*M* (Fin)	*M* (US)	*SD* (Fin)	*SD* (US)	*N* (Fin)	*N* (US)	*d*
Group care consultation							
Q15 T	3.19	4.61	2.10	1.72	43	492	0.74
Q15 I	5.67	6.15	1.82	1.27		390	0.31
Home-based model							
Q16 T	3.20	4.01	1.47	1.36	35	492	0.57
Q16 I	6.29	5.60	0.987	1.50		425	−0.54
Home visitor's role							
Q17 T	4.68	4.49	1.47	1.34	38	492	−0.14
Q17 I	6.41	5.77	0.821	1.10		429	−0.66
First encounters							
F1 T	4.35	5.07	1.45	1.18			0.55
F1 I	6.14	6.06	0.994	1.01			−0.08
Intervention planning							
F2 T	4.54	4.94	1.47	1.37			0.28
F2 I	6.25	6.23	0.881	1.06			−0.01
Functionality							
F3 T	4.86	5.72	1.44	1.16			0.66
F3 I	6.21	6.50	0.839	0.789			0.36
Service delivery							
F4 T	3.72	4.46	1.84	1.47			0.45
F4 I	6.15	5.83	0.981	1.25			−0.29

all 4 areas were higher than Finnish scores, with the differences in functionality and first encounters being moderate and the differences in service delivery and intervention planning being small. In ideal practices, American mean scores were slightly higher for functionality, and Finnish mean scores were slightly higher for service delivery.

DISCUSSION

Summary of findings

The purposes of this study were to determine the state of current practice in early intervention in Finland and compare them to American data. Comparisons between Finnish early intervention and American early intervention are difficult, because the systems are quite different. The practitioners in this Finnish study endorsed the practices on the FINESSE, as indicated by their consistently higher ideal-practice scores, compared with their typical-practice scores. This pattern of responding is usual for these typical-ideal discrepancy tools (Bailey et al., 1992; Björck-Åkesson & Granlund, 1995; Granlund & Björck-Åkesson, 1996; R. A. McWilliam et al., 2000; R. A. McWilliam & Bailey, 1994). Social desirability might explain this pattern because respondents can see that the higher ratings are consistent with recommended practices. They would, therefore, be likely to rate their ideal practices quite high on the scale. Nevertheless, the data can be taken at face value—that these respondents considered the items to be ideal.

First encounters

How early intervention is first presented to families is considered an important step in setting the stage for families' expectations (P. J. McWilliam, 1999). The items comprising this factor on the FINESSE emphasize early intervention as support rather than just services.

In Finland, according to the current data, this might be less common than in the United States. This study shows that typical practices appear to reflect a different approach to early intervention in the 2 countries. One of the benefits of the FINESSE has been to document such international differences (R. A. McWilliam & Er, 2003).

Intervention planning

This set of items emphasizes the use of families' reports of child and family functioning in routines (R. A. McWilliam, 2005). Finnish scores did not differ from the US scores by much; in both countries, the process of intervention planning, such as assessment, appears to be based more on tests than on routines-based needs. Traditional tests will inform the level of child development (see Vehkakoski, 2003), but they do not offer the information of how to support the child. When planning the intervention, it is essential to ask parents to evaluate their daily routines, because the satisfaction of life is highly based on fluency of routines in natural environment. This kind of information offers important knowledge about family's informational, material, and emotional needs, which are the main areas of intervention planning (R. A. McWilliam & Scott, 2001).

Functionality

Functionality items emphasize interventions occurring in the context of everyday routines, rather than occurring out of context. Relative to the other factors in the FINESSE, this was the strongest area in the current study. It still differed from the US means, because it is also the strongest area in the United States. The importance of intervening with young children in their daily routines and supporting natural caregivers to take advantage of learning opportunities has been well articulated by Dunst, Bruder, Trivette, Raab, and Mclean (2001). Also, in Kovanen's study (2002), teachers emphasized learning in everyday routines with other children, although in practice they seemed to favor individual teaching. Kovanen supposes that there might be a lack of skills and knowledge of naturalistic and comprehensive approaches.

Service delivery

The service delivery items emphasize the early interventionist's role as a consultant, which highlights an essential difference between Finnish and American early intervention services: Very little home visiting is done in Finland. Not surprisingly, then, this was the least family-centered and naturalistic of the 4 factors in the FINESSE. It was also the lowest among the US data, but Finnish scores were even lower. Finnish respondents, however, valued a more family-centered and naturalistic approach, as could be seen from the ideal-practice scores. Large discrepancies were found between Finnish typical and ideal practices. In this area, they were actually marginally higher than the US ideal-practice scores.

Limitations

The number of respondents in this study might be too small to make broad generalizations. Furthermore, insufficient information about the respondents was obtained to be able to understand fully the range of types of professionals providing their perspectives.

A second limitation is that these data reflect professionals' perspectives, which might differ from families' perspectives, as was seen in the results of the Finnish family "barometer" in 1999 and 2000 (Reuna, 1999; Seppälä, 2000). Ascertaining how families experience early intervention would be a reasonable complement to the current study.

CONCLUSION AND IMPLICATIONS

Three broad conclusions can be drawn from these data. First, the administrative structure for providing early intervention services in Finland could be expanded to include more specific guidelines on how to support families. Similar conclusion was summarized in Kovanen's study (2001). Yet, some recommendations about parent partnership and special support already are given in the document

National Curriculum Guidelines on Early Childhood Education and Care in Finland, 2003. In addition to guidelines, increasing and developing home visits could be one way to advance early intervention practices, although it is acknowledged that there is a need to examine intervention strategies of home visits (Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007). In the current study, home visits were seen as one way to support the family in daily routines in a concrete way. The rationale for home-based services is that (1) child's natural environment is an efficient place to support the family, (2) it provides access to all families in that they would not have to travel to receive services, and (3) research shows that home-based professionals report using more family-centered practices than do center-based professionals (R. A. McWilliam, 2003; R. A. McWilliam et al., 2000).

Second, the current study shows differences between Finnish and American service deliveries but no data on outcomes for children and families were assessed. Before rushing to change, it would be worthwhile comparing the results of the 2 models. Third, reasons for the discrepancies between typical and ideal practices should be explored. This would guide policy makers, university faculty, inservice trainers, and managers about resources they could provide to help practitioners work in ways they perceive to be best.

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