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COLLABORATION IN THE ASSESSMENT AND DIAGNOSIS OF PRESCHOOLERS: CHALLENGES AND OPPORTUNITIES

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The preschool assessment and diagnostic process offers many opportunities for collaboration across disciplines that can enrich the professional's understanding of the young child. This article addresses the advantages and complexities of such collaboration including opportunities for infusing collaboration across the multiple steps of assessment. Challenges commonly seen in a collaborative process, involving issues of time, decisions regarding diagnosis and recommended interventions, shared responsibilities, conflict across disciplines, and the need for administrative support, are explored. Special issues around creating meaningful partnerships with families are examined with attention to fully including families at whatever level they are comfortable. Finally, trends in consultation and collaboration that require the specialized expertise of preschool psychologists are described, along with promising models of training that incorporate collaboration, consultation, and policy work into the pre-service experience. © 2011 Wiley Periodicals, Inc.

Three-year-old Anna was referred to the school psychologist shortly after the school year began. Her preschool teacher is concerned about Anna's inability to attend group activities and her flat affect, limited eye contact, hypersensitivity to touch by others (and extreme response when a classmate accidentally brushes into her), long periods of staring into space, limited expressive language, and lack of interest in engagement with peers and most classroom activities. This is Anna's first year at this school because her family moved to the community the month before school began.

It is often unclear how comprehensive or far reaching an assessment process will need to be when a preschool child is first referred for assessment. Clearly, cognitive assessment, social–emotional assessment, assessment of motor and adaptive skills, evaluation of speech and language, and information related to medical history, family background, risk, and demographics are important components of any thorough assessment process. But where do we place a priority focus, and are there disciplines that should be involved in every assessment or should some professionals only be relied on to answer specific types of questions raised by the assessment and diagnostic process?

In looking briefly at the referral information about Anna, individual professionals may begin to hypothesize about a variety of possible reasons for Anna's behaviors: Is she exhibiting signs of autism? Does she have developmental delays that are restricting her responses and interactions? Could she have a seizure disorder that is undiagnosed? Does she have some type of regulatory disorder? Has she experienced trauma? Is she depressed? Is she displaying signs of grieving? The emphasis placed on any given area may change somewhat when we begin to gather more information. If we learn that Anna's mother died suddenly in July, our assessment process may change direction, with the significance of gathering extensive information related to background and family factors becoming clear. If we learn that Anna was in an automobile accident in August and suffered a head injury, our process may take a different direction, and our hypotheses about what may be going on may involve questions about possible seizures due to brain injury that will require collaboration with the medical professionals involved in her care. If we learn that Anna is in foster care and has just been placed in her fourth foster home in 2 years, the type of information and professional collaborators required changes yet again.

When working with preschool-aged children, collaboration across disciplines and appropriate communication among disciplines is of great value. Many children enter the assessment and

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diagnostic process for the first time as preschoolers and thus have no history in assessment. Working across disciplines to gather the information that may be needed to differentiate symptoms and sort through myriad child and family factors reduces the assessment burden on preschool children and their caregivers. In addition, coordination and collaboration reduce the diagnostic and intervention burden on any single discipline. A number of researchers and clinicians have previously noted the importance of flexible, family-driven, collaborative approaches using multiple informants in early childhood assessments linked to the provision of intervention and treatment services (Bagnato, Neisworth, & Munson, 1997; Bagnato, Neisworth & Pretti-Frontczk, 2010; Bagnato & Simeonsson, 2007; Epstein, Schweinhart, DeBruin-Parecki & Robin, 2004; Greenspan & Meisels, 1996; Meisels & Atkins-Burnett, 2000). This does, however, require significant time and coordination of effort, along with a belief in the importance of working as a member of a team. Vig (2009) points out that collaboration across early intervention systems and services remains a challenge in most communities despite federal mandates for such collaboration.

Further, the majority of school psychologists develop the skills needed for such collaboration and an understanding of its value only once they are employed, if at all. One example is a study conducted by Rubinson, Sweeny, Mowder and Sossin (2003) in New York, which indicated that only 30% of the preschool psychologists who responded had learned skills of collaboration prior to being hired. New York is not unique; most pre-service programs do not provide clear classroom or experiential learning activities related to the development of such skills. In addition, there is great variation across school districts in terms of the availability of multidisciplinary professionals who might help new practitioners to integrate such best practices in terms of early childhood assessment or to build collaborative teams.

The next sections of this article will describe some of the challenges commonly encountered in the collaborative assessment process, along with the strengths of such a process. Issues that must be addressed to build and improve interdisciplinary collaboration and training to enhance preschool assessment will be addressed throughout the article.

Challenges of Preschool Assessment: Time

High-quality, comprehensive assessment and diagnostic batteries for very young children require significant time, particularly when it is the first time the child is being assessed. Zero to Three (2005) recommends at least three to five different sessions of 45 minutes or more to complete the process required for diagnosis. The interview process alone may require several hours to gather information from the child, parents, other family members, preschool teachers, day care providers, other professionals in the community, and other agencies involved with the child and family. Observations in the home, school, and community require travel time in addition to the observation time and often need to be scheduled on multiple days. In addition, interpretation of complex data and integration of multiple sources of information into a clear and understandable report also require a great deal of time on the part of the clinician. Some community mental health agencies acknowledge the significant time needed and allow 6 to 8 weeks for the assessment process with children under the age of 5 years (Finello, 2005).

Administration of standardized protocols, such as the Wechsler Preschool and Primary Scales of Intelligence-III (Wechsler, 2002) may actually take anywhere from 45 minutes to 2 hours, depending on the child's age, pace, and time needed to warm up, despite instructions in the manual indicating that the average time for assessment of a child aged 2.6 to 3.11 years is 30 to 45 minutes, and the average for a child between 4.0 and 7.3 years is 45 to 60 minutes. When working with a very young child for the first time, the preschool assessment team must be skilled at gauging where the child's developmental level lies and where to begin the assessment process. Informally, one must screen

while watching a young child as he or she plays; engages with others in the classroom, playground, or clinic waiting area; moves between activities; and transitions to new settings. A preschooler may be functioning well below chronological age, and this will require quick adaptation on the part of team members (even if a standardized protocol has already begun) if the basal level of the protocol being used is too high for the child being assessed. In other cases, a young child may be extremely shy and withdrawn and may require less intrusive and nondirective activities to "warm up" for other parts of the assessment. Often, brief observation helps to determine such factors and where to begin the assessment process. Such a process can help to focus tasks and reduce the time required for highly directed activities in a young child with a short attention span.

Sharing responsibility for information gathering and working collaboratively during assessment can save significant time once the team is working effectively together. There are two common approaches seen in collaborative teams: (1) a "transdisciplinary" model that requires team members to be sufficiently trained across other disciplines so that they can actually function across these disciplines through a process of role release (Linder, 2008; Vig, 2009); and (2) an "interdisciplinary" model requiring the interweaving of expertise and shared responsibility for the assessment process. The level of collaboration and shared responsibility within teams utilizing an interdisciplinary model may range from each member conducting an assessment separately and meeting to discuss their findings and formulate plans for intervention, to a team in which members are physically present and collaborating during each phase of the assessment and generating a cohesive single report from the team.

Both transdisciplinary and interdisciplinary models contrast with multidisciplinary models, in which professionals work independently, with each person generating his or her own report and recommendations. Greater concerns have been expressed about ethical boundaries of psychologists around the role release demanded by the transdisciplinary process (Hochman et al., 2006; Kruger & Lifter, 2005), but many teams have successfully handled such concerns through the adoption of specific types of assessment processes, such as play-based approaches (Linder, 2008) instead of the use of comprehensive standardized instruments designed primarily for psychologists and requiring much more training and expertise. Both models require family involvement and shared responsibility for gathering background and child and family information, scheduling observations, conducting collaborative assessments, integrating information provided by other sources, and jointly developing appropriate diagnoses, usable recommendations, and logical intervention plans.

Limited research has been done to examine efficacy of these approaches, but one small study of 40 children randomly assigned to either a transdisciplinary, play-based or multidisciplinary, standardized assessment has been conducted (Myers, McBride, & Peterson, 1996). The results indicated significant time savings, more useful reports, and more favorable perceptions by families and professional staff for the transdisciplinary process. Vig (2009) outlines several additional advantages of a transdisciplinary team, including greater assurance that procedures and services are not duplicated and ability of team members to evaluate all areas of development, even when there are specific personnel shortages. The choice of a transdisciplinary or interdisciplinary model requires careful thought about the processes involved, reason for the assessment, and personnel who will make up the team, along with adequate planning on both administrative and service levels to insure success.

Challenges of Preschool Assessment: Diagnostic Issues

William is 4 years old and has been expelled from two previous preschool settings. His day begins at 7:00 a.m., when his mother drops him off at the extended day program run by his school. His preschool program begins at 8:45 and ends at 2:45 p.m., when he returns to the extended day program until pick up at 6:00 p.m. by his mother. William's teacher reports that he has age-appropriate cognitive skills but extreme behaviors when he is frustrated. When he becomes upset,

he screams at a high pitch, curses, and throws whatever is in reach. His peers approach him warily because of his volatile temper. William appears to be easily over-stimulated by noise and movement in his environment. He does not seem to be able to regulate himself when he begins to spiral out of control. His teacher reports that she cannot keep William in her classroom unless his behavior can be changed.

The primary reasons for referral and assessment of preschoolers are often different from those seen in a school-aged population, with large numbers of preschoolers referred because of behavioral issues. Preschool expulsion rates are extremely high (7 per 1,000) in contrast to rates of expulsion during the elementary, middle, and high school periods (2.1 per 1,000; Gilliam, 2005). Typically, preschool expulsions are due to problem behaviors that the preschool teacher is either not equipped or unwilling to handle. Many of the troubled behaviors seen in very young children can be linked to cognitive delays and language limitations (especially with speech- and language-delayed children) and reflections of their inner, confused world. Gaining information about underlying causes of problem behavior is important to understanding the problem, formulating a diagnosis, and creating appropriate interventions. Determination of the primary diagnosis and development of priority interventions is always enhanced by the collaborative team process.

Controversies around diagnosis in preschoolers relate as much to how symptoms are defined as to whether a condition is appropriately diagnosed during the preschool period. Most diagnostic categories focused on mental health issues and behavior problems are based on descriptions of symptoms seen in adults and older children and are poorly defined for preschoolers or too broad to be useful in formulating intervention plans. Developmental issues common during the early childhood period also mirror common diagnostic symptoms for specific mental health disorders. This includes a lack of compliance, oppositional behaviors, anxieties, and fears, all of which can be considered normative in young children. Imaginary friends are common in preschoolers, and children's literature abounds with vivid descriptions of companions best described as imaginary. At what point do such normative aspects of development cross the line and become categorized as atypical disturbances requiring mental health intervention? Is a child hallucinating? Suffering psychosis? Or merely exhibiting developmentally appropriate behavior? Are the family and teacher expectations too high for the child's functional level, leading to frustration and acting out? Should diagnoses of mental health conditions such as bipolar disorder or attention deficit hyperactivity disorder even be given during the preschool period, or are these inappropriate? Differentiating typical development and developmental stages versus disorder can be difficult. Further complicating diagnosis is when a cognitive delay is layered with behaviors that are developmentally appropriate for the child's functional age, but inappropriate for chronological age. However, it is clear that impairment in functioning, a criteria for diagnosis of behavioral and mental health problems in diagnostic systems, can be seen when examining the adaptive functioning of the young child exhibiting serious problem behaviors in a preschool setting.

Symptom description for diagnosis also relies on duration or intensity that does not map well onto the earliest periods of life. Luby and colleagues (Luby, 2010; Luby et al., 2002) argue for "age-adjusted symptom translations" for early childhood. They have done such translations for preschool depression with the understanding that symptoms such as anhedonia must be described very differently for very young children than for adults, using play themes, for example, rather than verbal descriptions of depressive symptomatology (Luby et al, 2003).

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3R; Zero to Three, 2005), originally developed specifically for children from birth to 3 years of age and expanded to include preschoolers, has been a step forward in terms of diagnosis of conditions in the birth-to-5 period. It has been adopted by many early childhood mental health practitioners as a useful tool for treatment planning, but most mental health reimbursement

systems demand use of diagnoses defined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) for billing purposes. In addition, many problems remain within this relatively new diagnostic approach, which was designed through clinical consensus and awaits validation in large population groups (Brassard & Boehm, 2007; Evangelista & McLellan, 2004). Further, early childhood psychologists who are based in school districts are required to use an even broader diagnostic criterion of "emotional disturbance," as described in the Individuals with Disabilities Education Act (Brassard & Boehm, 2007). More research is needed to define and formulate diagnoses that incorporate the complexity of individual child, family, school, and community issues in the early childhood period and contribute to the development of effective intervention and treatment strategies.

Specific Types of Diagnostic Challenges

A great deal of comorbidity exists among conditions seen during the preschool period, and many symptoms fit multiple diagnostic categories. For example, 4-year-old Jake shows a very restricted range of emotions, seemingly unable to demonstrate joy or any sign of happiness through his language or facial and body expressions. Even when Jake needs something, he does not indicate his need, waiting silently and still for an adult to notice and respond. Expressive language is limited, although Jake's receptive language skills seem age appropriate, and he responds consistently to adult demands. Jake does not demonstrate any enjoyment with his peers and does not initiate interactions with either peers or adults. His quiet, unobtrusive demeanor is overshadowed by his more rambunctious peers, who draw the frequent attention of their preschool teacher. In fact, the teacher has not reported any concerns about Jake, indicating that he is no problem in the classroom.

Based on the previous information, it is not clear whether Jake's symptoms are associated with developmental delay, post-traumatic stress disorder, depression, or some combination of these. In addition, most behavior screens do not measure factors such as the duration of the particular behavior, the time of onset (and co-occurring family conditions at time of onset), response intensity, or family expectations in a coherent manner. All factors are critical to understanding whether a problem behavior is a vexing temporary issue due to development or a more long-term condition that demands diagnosis and appropriate intervention focused on the diagnostic concerns. Further evaluation, tapping the expertise of early childhood team members, may help differentiate and more clearly define Jake's primary diagnosis. Meanwhile, significant research needs to occur, driven by clinical data around diagnostic issues, along with symptom translation relevant to early childhood, to assist with better categorization of early childhood behaviors and more appropriate and effective diagnoses and interventions.

What Is Needed for Adequate Collaboration and Coordination across Disciplines?

There are a number of factors critical to successful implementation of any team approach, whether it is interdisciplinary or transdisciplinary. These include: (1) a belief in the value of collaborative work; (2) an understanding of scope of practice and training issues for each discipline involved; (3) an ability to place individual egos on the shelf; (4) cross-disciplinary training and support within the team; (5) administrative support for the process; and (6) a mechanism to handle the internal conflicts that are inevitable.

An additional requirement for a preschool team is that each member has significant experience and understanding of development between birth and age 5 (Greenspan & Meisels, 1996; National Association of School Psychologists, 2005). This is critical in assessing preschool-aged children because many 3- to 5-year-olds are referred due to delays, and their functional levels may be in the infant/toddler range.

Partnering with Families

Involving a family in the assessment process must go beyond just the interview to gather information about background and developmental history. Sound assessment incorporates knowledge of the fact that multiple, complex factors underlie a young child's functioning (Greenspan & Meisels, 1996). This must be communicated effectively to the child's family so that they are not bewildered by the fact that so many questions are being asked that do not appear to be focused on the referring problem or the child.

A genuine transdisciplinary team demands the inclusion of parents as full, active assessment partners (Bagnato & Neisworth, 1991; Berman & Shaw, 1996; Brassard & Boehm, 2007; Division of Early Childhood [DEC], 2007; Greenspan & Meisels, 1996; Woods & McCormick, 2002). Clinical reports have indicated that at least 50% of families may not follow through with recommendations that are provided. The reasons for lack of follow through may range from inability to understand the recommendation to a lack of agreement with the recommendation, to an inability to access recommended services because of communication and other barriers. The first step in ensuring that a family follows through with recommendations is early engagement and partnership so that the family feels that the recommendations were driven by their own information and desires (Bailey & Powell, 2005). Recording verbatim responses from parents during feedback sessions and writing reports of such statements may also help to strengthen and support assessment findings.

Having the parent involved as a full and equal partner during assessment of a preschooler is of great value in that it assures the parent that the process is fair, invests the family in the process, helps the child feel more comfortable in an unusual situation with many adult demands, and affords a different look at child and family functioning. Full involvement of the family in early childhood assessment has long been advocated by leading clinicians, researchers, and organizations in the early childhood field (Bagnato & Neisworth, 1999; Bagnato et al., 1997: Berman & Shaw, 1996; DEC, 2007; Greenspan & Meisels, 1996; National Association of School Psychologists, 2005), and models for family-focused services and empowerment have been developed by Bailey and Simeonsson (1988) and Dunst, Trivette, and Deal (1988). Family partnerships improve the capacity of school psychologists to understand the preschool child's ability to work independently, to respond to multiple adults, and to deal with external demands, in addition to providing the opportunity to gauge caregiver ambivalence, caregiver intrusiveness in the process, the child's ability to ignore distractions in the environment, and the child's interest in novel activities. Such knowledge can provide a better and more comprehensive snapshot of child functioning, better insight into intervention planning, and greater potential for follow through with recommendations on the part of the family.

Steps in a Collaborative Process

The collaborative process should occur across the many steps in a comprehensive evaluation. This includes the information-gathering phase, the direct evaluation involving the young child, the process of developing recommendations and intervention strategies, writing of an integrated report, and the feedback sessions and meetings with families and other professionals following the assessment. Each of these will be described in the next sections.

Gathering Critical Information

Every preschool assessment requires a review of existing documents, incorporation of old and new information, interpretation of findings across disciplines, sorting in terms of priority needs, formulation of appropriate primary and secondary diagnoses, and development of an integrated report with prioritized recommendations. A comprehensive preschool assessment will require information

in a wide range of areas including (but not limited to): family strengths and risk factors, parenting characteristics and beliefs, child medical and health issues, neurodevelopmental issues, temperament, regulatory behaviors, adaptive behaviors, behavioral concerns, speech and language skills, functional levels in all areas, sibling relationships, family relationships, peer functioning, community stressors, economic resources available to the family (DEC, 2007; Greenspan & Meisels, 1996; Meisels, 1996; Nagle, 2007; National Association of School Psychologists, 2005). These critical components of the assessment and diagnostic process are best done in a collaborative team setting.

Clearly, some professionals will have greater training and experience in gathering information within specific arenas, and it is most efficient to have them pull such data together to discuss collaboratively the meaning of the data and next steps in assessment and diagnosis. For example, gathering complex documents from health care providers about a preschool child's medical history is crucial. Ensuring that all records are up to date and that any current health services being provided are documented and described, along with their potential impact on the developing child, is also important. A medical professional who is a member of the preschool team can be of great assistance in gathering such information, reviewing it, and helping to make sense of it for nonmedical team members.

Most comprehensive assessments for preschool children are conducted in a clinical setting within the school environment. This presents additional challenges for the preschool psychologist when attempting to measure family strengths, risk factors, and home and environmental issues. Relying on interdisciplinary colleagues who may be able to gather such information and tapping into the preschool teacher's knowledge of the child and family situation can be extremely valuable if the child has been in the classroom long enough for the teacher to develop such knowledge.

Conducting the Assessment

Significant limitations exist in standardized test protocols developed for children between birth and age 5. Most tests for this age group are split into the infant and toddler range or the preschool range with limited overlap. Preschoolers with significant delays often fall out of the standardization sample and may best fit into a procedure developed for the younger age cohort, which may involve a totally different test not standardized for such ages. For example, if the 4-year-old child being assessed is functioning at 18 months, standard cognitive batteries such as the Stanford-Binet Intelligence Scales (5th ed.; Roid, 2003) and Wechsler Preschool and Primary Scales of Intelligence (3rd ed.; Wechsler, 2002) have basal levels that are too high, and the Bayley Scales of Infant and Toddler Development (3rd ed.; Bayley, 2005) were not standardized on delayed 4-year-olds. Other limits of most standardized test protocols include the fact that most are flat, without sufficient depth to capture the full range of strengths, emerging capacities, and differences between new skills and those deeply entrenched in the child's developmental process. The collaborative process permits richness in looking at the child's strengths and areas of challenge that is much deeper than the view by unitary disciplines relying on standardized protocols with limited age ranges.

Collaborative and team-based assessments may require bending procedures outlined in test protocols to accommodate child personality, family factors, and interdisciplinary assessment needs. For example, it may be necessary to imbed additional motor items into the protocol for a standardized cognitive assessment to accommodate the needs of the occupational or physical therapist trying to gauge motor skills. Many items required may be identical across several different unitary disciplinary procedures; instead of requiring a 3-year-old to do the same activity for each assessor, sharing the process allows all to score simultaneously while one actually conducts the procedure. Determining at the outset what overlaps exist and how they might best be handled streamlines procedures and reduces the burden on all involved. Such streamlining also helps to maximize the preschool child's performance as it reduces the potential impact of fatigue and boredom.

Team members must work to read the young child and caregiver's body language for cues about what is not being said in the room and to understand how to respond to such cues in a nonthreatening manner. They must also make an effort to keep young children on target, moving at their individual pace, paying attention to distractions in the environment and how they are impacting performance, and maximizing flow between individual processes of assessment (including changes in team leaders for various protocols).

Developing Cohesive and Logical Recommendations and Interventions

Developing recommendations based on priorities when multiple disciplines are involved can be a further challenge, particularly when each discipline has been trained to believe in the importance of the type of interventions they provide. Most professionals believe that their skill sets are critical in the child's developmental progress or they might be in a different profession. Continuous and meaningful dialogue between members of the professional team and the family is critical to determine a priority list of recommendations and to determine how best to intervene with early problems. Sometimes, the list of recommendations and accompanying interventions is so long that it is daunting to the family. Bailey and Powell (2005) provide useful suggestions regarding how to query families about their needs and wishes for support. Discussing family needs, goals, and timelines for implementation can be extremely helpful in decisions about where to focus first. This also ensures that both recommendations and intervention practices are truly "family driven" and goes a long way toward insuring that recommendations are actually addressed and implemented.

Preparing Integrated Written Reports

Collaborative report writing requires training, practice, and assistance to hone skills. Clinicians must integrate extensive, complex information that provides an ecological perspective of the child's functioning through the interweaving of data regarding child characteristics and current functional levels, behavior across settings, family factors, cultural issues, and societal factors. In many collaborative teams, responsibility for preparation of a final, integrated report rotates among team members. Whoever is responsible must integrate the information into a coherent, understandable, yet concise report. True collaboration demands the omission of disciplinary jargon so that anyone reading the report fully understands what is being said regarding the preschool child's current functional levels, strengths, potential deficits, and recommended strategies for intervention. Anyone can use complex jargon; the truly exceptional professional can express findings in language that everyone understands and shares. Every report should be prepared so that any parent or professional who reads it understands what is being said without lengthy "interpretation." Words and phrasing must be chosen carefully so that all pertinent information is conveyed in a thorough yet family-sensitive style, providing a picture of the complexity enveloping the preschool child's development and function. How recommendations are written and phrased is also important—these must be understandable to others outside of individual disciplines, including families, pediatricians, and other community professionals. If information sounds too esoteric, it misses the mark.

Improving Oral Feedback Procedures

A collaborative approach requires that each team member develop his or her skills of integrating complex information to provide a seamless picture of the young child that everyone can recognize and agree on and is comfortable with describing this information orally. There are many anecdotal stories related to problems encountered during Individualized Education Programs (IEPs) and other feedback sessions. An early interventionist tells the story of Ada, a severely delayed 3-year-old girl

who had no vision and was being evaluated for special developmental services. During the IEP meeting following a multidisciplinary assessment process, the psychologist's computer-generated report was shared with the family, preschool teacher, and others on the team. Ada was described as functioning at age level, with numerous examples of her ability to complete tasks that required vision. It became clear that Ada had been mixed up with another child when the report was generated and submitted by the professional whose services were by contract to the school district (and who was not present at the IEP meeting). The other professionals attending the meeting (who had not met to work together to generate a collaborative, integrated report but instead presented a long and dreary list of individual reports, each with their own set of recommendations) were understandably embarrassed and asked the family to return in another week to allow them time to access the correct information.

Such an example is egregious but unfortunately not rare. It is easy to make a mistake when pulling up a report or to reference "he" instead of "she" when preparing multiple computer-generated reports in a short period. However, it is critical that the professionals who have assessed the preschool child meet ahead of the family meeting to verbally discuss their findings and recommendations and to begin to prioritize what would be the most appropriate interventions that could be offered within the school and community, even when assessments were conducted independently. The focus of the family meeting can then be on sharing more integrated findings about the child's current status and determining what the family views as priorities for intervention at this time. Such an approach is both child- and family-sensitive and practical in terms of the use of everyone's time.

When working with families of very young children who are entering systems for the first time, "warm referrals" are also of great value. Such referrals require introductions across agencies and organizations, inviting participation by outside agencies during feedback sessions so that a referral is more than a written name on a sheet of paper, or actually accompanying a child and family to the program to which they are being referred. A collaborative process insures that this will happen more efficiently and regularly.

Limitations in the Collaborative Process

Administrative support for the collaborative process is essential. Even though individual disciplinary assessment time might be reduced, a team process requires specific planning and meeting time to do the work. Because of the potential for confusion regarding individual roles and responsibilities, particularly when there is role release in a transdisciplinary process (Vig, 2009), roles and responsibilities must be clearly delineated and addressed on an ongoing basis. Thus, appropriate models for supervision and support are critical to the ongoing success of collaborative preschool teams.

Conflict may also occur both at the beginning of the team building when the process is new and turf issues and ego issues arise, and periodically throughout the process as disagreements surface regarding assessment processes and intervention priorities. A team approach creates significantly more openness in assessment, with individual expertise being evaluated and "judged" on an ongoing basis by both families and other professionals. This can create discomfort in many individuals if they are not well supported and if underlying conflict is not addressed. There are also differences in "goodness of fit" between professionals and young children. Maximizing opportunities for young children to engage at optimal levels by capitalizing on such goodness of fit is important. This can, however, create tension for the team, particularly if there is rigidity in individual members.

Clearly, there is also great variation in the ability of individual families or family members to participate fully as members of a collaborative team. Many families of very young children are not

yet ready to engage as full partners or may feel uncomfortable with the concept because of their own histories or culture (Ginsberg & Hochman, 2006). Adapting the collaborative processes to fully include families at whatever level they are able to manage is important.

Current Trends and Promising Future Practices for Preschool Psychologists

Increasingly, school psychologists are being called on to provide consultation related to teacher stress, burnout, family risk factors, behavior management within classrooms, and issues of child behavior in extended day settings, the home, and the community. There have been growing family and classroom expectations, with increasing demands placed on both teachers for accountability and on very young children to demonstrate a narrowly defined vision of "school readiness" through a variety of state and federal legislation. Young children have moved from a play-centered world to a very rigorous academic environment with demands for strong self-regulation, self-control, behavioral inhibition, and coping. Many young children are not developmentally ready for the inherent academic challenges. In the school setting, the psychologist may be asked to do teacher mentoring or provide parent education programs. Such work may involve helping to create broader perspectives in early care and educating providers, preschool teachers, and parents about the behaviors that should be expected of children based on their functional ages, not chronological ages.

Consultation issues include providing ideas and strategies to preschool teachers, families, and day care providers based on child strengths and needs to improve the young child's behavioral functioning and to assist adults in understanding the potential underlying reasons for behavior. This is particularly important, considering the large number of young children "expelled" from day care and preschool settings resulting from behavior (Gilliam, 2005; Gilliam & Shahar, 2006). Gilliam's (2008) findings of an association between higher teacher stress and longer days spent in classrooms with more expulsion of preschoolers point to the need for consultation by school psychologists to assist preschool teachers in dealing with problem behaviors in young children, modifying their classrooms to better meet child needs, and recognizing the impact of their own stress on the children in their classrooms (Gilliam, 2007, 2008, 2009).

School psychologists may also rely on their skills and background to build relationships among families, the schools, and the wider community as part of their consultation strategies. This may involve developing closer links to community providers (e.g., physical therapists, neurologists, mental health therapists, and pediatricians) or helping diffuse or "cool off" volatile relationships that may have developed between the home and school setting due to misunderstandings and communication issues.

More school psychologists are also being tapped to design or deliver prevention programs in the school setting or community that move well beyond what has typically been considered the realm of the school psychologist. As attention under health care reform becomes focused on preventing problems in addition to intervening with existing problems, school psychologists and their professional colleagues may need additional interdisciplinary and collaborative skills. School psychologists will increasingly be asked to utilize their understanding of family problems and risks that may be impacting preschool behavior to develop preventive interventions to reduce behavioral risk in young children and to support teachers and families in supporting the child (Evangelista, 2009). Preventive approaches may also involve issues such as how to link young children and their families to a medical home, the integration of emotional and physical well-being as interventions are planned, and strategies focused on reducing risk factors in very high-risk young children and their families with the hope of reducing later developmental and learning problems. Evangelista (2009) also notes the role of preschool psychologists in designing more appropriate early learning environments and in providing leadership and advocacy on behalf of young children and their families. Alfonso and Flanagan (2009) further note the continuing need for outcome assessments by appropriately trained

early childhood psychologists, as the extensive and growing literature demonstrates the efficacy of early intervention services.

Training is required to become proficient at juggling all of these features of the expanding role of preschool psychologists. There are some school psychology training programs that are beginning to address such training needs. This includes programs that are incorporating community agency placements so that students learn more about other disciplines and the needs of children and families or that use a public health orientation, focused on the interaction of individual characteristics and societal issues to frame their training approaches. These unique models include helping students to develop skills of collaboration through a hands-on approach, with placements in a wide range of community agencies that serve children and in state agencies that set policy for education or mental health. Such placements allow students to develop collaborative skills in live settings and to gain policy experience firsthand (Parkin & Pate, 2007) and show great promise for the field. An additional resource for interdisciplinary clinical and leadership training at the graduate level are the 39 federally funded Leadership in Neurodevelopmental and Related Disabilities (LEND) programs located in universities across the United States (see www.aucd.org for locations). With growing demands placed on school psychologists, training programs throughout the country need to explore such opportunities for providing more comprehensive training related to meeting collaboration and consultation needs at both pre-service and continuing education levels.

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