Effectiveness of a Sensory-Enriched Early Intervention Group Program for Children With Developmental Disabilities

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MeSH TERMS
- developmental disabilities
- early intervention (education)
- patient care team
- sensation
- treatment outcome

OBJECTIVE. The study’s objective was to evaluate the effectiveness of the Interdisciplinary Sensory-Enriched Early Intervention (ISEEI) group program for children with developmental delays.

METHOD. We conducted a retrospective chart review of 63 children ages 18–36 mo who participated in ISEEI. We evaluated participants with the Bayley Scales of Infant and Toddler Development III (Bayley–III) and the Infant/Toddler Sensory Profile (ITSP) at enrollment and after 3–9 mo. We conducted a paired t test to examine changes in the Bayley–III between pre- and posttests.

RESULTS. At enrollment, 70% of children presented atypical scores in two or more areas of sensory processing in the ITSP. Results revealed that children with sensory processing difficulties demonstrated significant improvement in all areas of development except fine motor skills; children without sensory processing difficulties showed significant improvement in language and cognition.

CONCLUSION. The ISEEI group program is an effective method to ameliorate developmental delays.

With the implementation of Part C of the federal Individuals With Disabilities Education Improvement Act of 2004 (Pub. L. 108–446), the importance of providing early intervention (EI) to children with developmental delays is no longer questioned. Yet, several challenges arise in providing EI. These challenges include choosing appropriate intervention models to accommodate for the complexity in developmental trajectories resulting from the diversity among families and children’s diagnoses (Guralnick, 2011). Models developed to address specific challenges of the diversity of EI recipients tend to address either biological and environmental risks or specific diagnoses. For example, programs measuring the effects of EI on low-birthweight and premature infants during the first 3 yr of life reveal significant intervention effects in cognitive, motor, and socioemotional development (Blauw-Hospers, de Graaf-Peters, Dirks, Bos, & Hadders-Algra, 2007; Bulotsky-Shearer et al., 2012).

Other EI programs are dedicated to a specific diagnosis such as autism spectrum disorder (ASD). Such programs involve sensory elements in their design, but the focus of the intervention is not necessarily on the effects of sensory processing on development. One example is the Early Start Denver Model (Rogers & Dawson, 2009). Delivered to 48 toddlers with ASD, this model resulted in positive changes in IQ, language, and adaptive behavior (Dawson et al., 2010). Another example is the Social Communication Emotional Regulation Transactional Support (SCERTS) Model, a family-centered program focusing on...
communication, self-regulation, and socioemotional abilities. This program resulted in positive changes in those areas (Prizant, Wetherby, Rubin, & Laurent, 2003).

The diverse needs of children attending EI programs require both choosing specific theories and evidence to support a program and following existing recommendations for best practice. In choosing specific theories, some authors recommend a Developmental Systems Model approach (Guralnick, 2011), whereas others use movement science theories in their intervention (Hickman, McCoy, Long, & Rauh, 2011). However, even when occupational therapy practitioners have consistently been key members of interdisciplinary EI teams, the systematic application of Sensory Integration (SI) theory (Ayres, 1972; Ayres, 1979, as cited in Ayres, 2005; Parham & Mailloux, 2015) in a group EI program has seldom been researched. Moreover, review of the literature suggests mixed results for EI programs in which occupational therapists participate.

In a recent review of the literature on existing developmental interventions for children ages 0–5 yr, Case-Smith, Frolek Clark, and Schlabach (2013) described interventions with children ages 0–3 yr as having low positive short-term effects and no evidence of long-term effects regarding their motor outcomes. However, interventions that included behavioral and learning objectives appear to have positive results. Another review by Kingsley and Mailloux (2013) identified parenting programs and interventions occurring in family routines as having positive effects; however, evidence supporting one type of service delivery over another was insufficient. Kingsley and Mailloux concluded that more studies were needed to better understand the effects of dosage, service delivery models, timing, and duration of the EI programs.

In the development of the program described in this article, Interdisciplinary Sensory-Enriched Early Intervention (ISEEI), SI theory (Ayres, 1972; Ayres, 1979, as cited in Ayres, 2005) was chosen as the theoretical model for the program’s conceptualization and delivery. This choice was based on the observation that 70% of the children referred to ISEEI presented sensory processing difficulties as evaluated by the Infant/Toddler Sensory Profile (ITSP; Dunn, 2002).

SI theory, first developed by A. J. Ayres (1972), is based on understanding the impact of having the ability to organize sensory information for learning. Thus, creation of the therapeutic situation requires carefully monitoring how the child meets environmental challenges by producing adaptive responses (Ayres, 1972; Parham et al., 2011). SI intervention approaches can be categorized in two ways: as an individualized treatment using sensory-rich play activities guided by the child in a specialized setting, referred to as SI treatment, or as the use of sensory strategies guided by the adult in a variety of environments, referred to as sensory-based intervention (SBI; Case-Smith, Weaver, & Fristad, 2015). The individualized treatment approach, also referred to as Ayres Sensory Integration® (ASI), is delivered in a one-to-one ratio by trained professionals in a specialized clinical environment (Parham et al., 2011). However, sensory strategies as a form of sensory-based interventions can be used in a variety of physical environments and delivered by teachers, parents, and other personnel under the supervision of a trained professional (Case-Smith et al., 2015).

ISEEI is based on the use of sensory strategies, including an enriched environment, guided by SI theory. Sensory strategies include the use of weighted vests (Fertel-Daly, Bedell, & Hinojosa, 2001; Hodgetts, Magill-Evans, & Misiaszek, 2011; Lin, Lee, Chang, & Hong, 2014) and adaptive seating (Bagatell, Mirigliani, Patterson, Reyes, & Test, 2010; Fedewa & Erwin, 2011; Pfeiffer, Henry, Miller, & Witherell, 2008; Schilling & Schwartz, 2004; Schilling, Washington, Billingsley, & Deitz, 2003; Wu et al., 2012). Results of studies using adaptive strategies have been mixed, but as research on these strategies has accumulated, their effectiveness has been clarified. For example, the use of weighted vests with children with ASD to reduce maladaptive behaviors has been questioned (Davis et al., 2013), but its use as an aid to increase in-seat behaviors has shown promising results (Lin et al., 2014).

Other sensory strategies include the use of sensory breaks in an enriched environment (Mahar et al., 2006; Parham & Mailloux, 2015) and the use of multisensory rooms, which may use Snoezelen equipment (Carter & Stephenson, 2012; Fava & Strauss, 2010; Stephenson, 2002). Enriched environments and sensory strategies are often incorporated into EI group programs; however, measuring the specific results of such an approach has been done less often.

The development of a program also requires following existing recommendations for best practice. According to Sullivan, Stone, and Dawson (2014), the following factors support the effectiveness of EI for children with ASD: provide the intervention early (younger than age 1.5 yr), use an intensive and interactive format, address social interactions and arousal modulation, and use multisensory and multimodal teaching approaches. Wallace and Rogers (2010) also included parental involvement through coaching and training. Moreover, the recommendations of the National Academy of Sciences and National Research Council (2001) include entry into an intervention program...
as soon as the diagnosis of ASD is made, program intensity of at least 25 hr per week, interventions organized into intervals of 15–20 min, inclusion of a family component, low student-to-adult ratio (3:1), and completion of ongoing assessments of children’s progress. Although only a fraction of children in ISEEI were diagnosed with ASD, these recommendations were used in the conceptualization of the program.

Powell (2014) stated that EI programs can be grouped into three categories of parental involvement: child focused, parent education focused, and child and parent focused. Child-focused EI programs are often center based, run by professionals, and focus on children with disabilities. These programs include parental involvement as an adjunct to the intervention, not necessarily as the focus of it (Powell, 2014). Programs that include a parent component have consistently been reported to produce better results than those without (Kasari, Gulsrud, Wong, Kwon, & Locke, 2010; Prizant et al., 2003).

Several SI models are used to accommodate for the diversity that exists among families and their children’s diagnoses. Although SI theory is one of the main occupational therapy treatment theories used with children, no studies have focused on its application in group EI programs. ISEEI is a group program using current recommendations for EI and SI theory in its conceptualization and delivery. Therefore, the specific research aims in this study are to examine the effectiveness of ISEEI, a manualized, interdisciplinary EI group program, on development as measured by a standardized developmental assessment and to determine the effects of ISEEI on children with sensory processing difficulties.

Method
On the basis of data collected in a community setting, we conducted a retrospective study of the ISEEI group program delivered to children between ages 18 and 36 mo identified as having delays in motor, cognitive, or language areas or a combination of these areas.

ISEEI Program
The ISEEI program was designed by occupational, physical, and speech–language therapists to be led by therapists, teachers, and aides in direct consultation with the therapists. Each group encompassed as many as 12 children and 4 adults, with a 1:3 ratio of adult to child. The program included monthly in-home consultations, community activities such as visits to parks and other recreational facilities, and parent training courses that focused on themes related to their child’s development. Children attended ISEEI 2 or 3 times per week for 3 hr each day. The program followed a prescribed protocol, with monthly themes covering several developmental areas, including social interaction, gross and fine motor development, language and communication, and cognitive development. Individual goals were developed for each child on the basis of initial assessment, parent concerns, and the child’s developmental and medical history. Review of progress toward goals was completed every 3–6 mo.

The uniqueness of ISEEI lies in its focus on the impact of sensory processing on development and behavior, hence the use of a delivery model based on SI theory (Ayres, 1972; Ayres, 1979, as cited in Ayres, 2005). All children spend 30–45 min per day in a sensory-enriched gym that includes suspended equipment, tactile media, and climbing equipment. The clinical setting meets the fidelity requirements for an ASI physical layout (Parham et al., 2011). Additionally, sensory strategies are used during other activities, such as table-top activities, language groups, and circle time.

Participants
The participants in this study consisted of a convenience sample of 63 children between ages 18 and 36 mo (mean $M = 28.7$ mo, standard deviation $SD = 4.1$ mo) identified with developmental delays in motor, cognitive, or language areas or a combination of these areas. Forty-one (65%) of the children were boys. The participants completed 3–9 mo of ISEEI ($M = 5.96$ mo, $SD = 1.74$ mo) between 2008 and 2010. The children represented several ethnicities, including White, Hispanic, African-American, Asian, and Persian. The most frequent reasons for referral were speech delays and social issues (41%), overall developmental delays (40%), genetic and neuromotor disorders (9%), and a diagnosis of ASD (8%). After discharge from ISEEI, an additional 9 children in this group were diagnosed with ASD, bringing the total percentage of children diagnosed with ASD to 22%. The 63 children were divided into two groups: (1) 44 children identified with sensory processing difficulties as evidenced by two scores at least 1.0 $SD$ below the mean on the ITSP and (2) 19 children not identified with sensory processing difficulties according to scores on the ITSP.

Instruments
All children were evaluated upon entering ISEEI with the ITSP and the Bayley Scales of Infant and Toddler Development III (Bayley–III; Bayley, 2006a). The Bayley–III was readministered to the children after they attended
ISEEI for 3–9 mo as a measure of progress toward individual goals, developmental progression, and establishment of new goals.

The ITSP is a standardized norm-referenced caregiver questionnaire for children ages birth to 36 mo that measures the frequency with which caregivers observe their child’s behaviors or responses in relationship to sensory experiences (Dunn, 2002). Caregivers respond on a 5-point Likert scale to indicate frequency of observed behaviors from almost always (5 points) to almost never (1 point). In the toddler version for children age 7–36 mo, 48 questions address five sensory processing categories (Auditory, Visual, Tactile, Vestibular, and Oral Sensory), four quadrant scores (Low Registration, Sensation Seeking, Sensory Sensitivity, and Sensation Avoiding), and a combined score for low threshold. Compared with population means, scores that fall within 1 SD of the mean are considered typical, scores that fall between 1 and 2 SDs from the mean are interpreted as a probable difference, and scores that fall more than 2 SDs from the mean are interpreted as a definite difference. Dunn (2002) found that the ITSP was able to detect significant differences in sensory processing patterns when using a multiple analysis of variance matched-sample comparison of children identified with developmental disabilities with typically developing children.

The Bayley–III is a standardized norm-referenced test that measures the performance of children between age 1 and 42 mo in the areas of cognition, receptive language, expressive language, and fine motor and gross motor skills (Bayley, 2006b). It also includes a parent questionnaire to measure social–emotional and adaptive behaviors. Each item within the cognitive, language, and motor categories is assessed and receives a score of 1 if the child’s performance meets the criteria or 0 if it does not. According to the child’s age, raw scores are converted into scaled scores for each performance area. The conversion tables are provided in the manual. Scaled scores have a mean of 10 and a SD of 3. Scaled scores that fall between 7 and 13 are considered average performance for a given age (Bayley, 2006b). Scores of 13 and above indicate performance above the mean for that age.

The Bayley–III is a reliable instrument with correlation coefficients of .86 for the Fine Motor scale; .87 for the Receptive Communication scale; and .91 for the Cognitive, Gross Motor, and Expressive Communication scales (Bayley, 2006b). It also provides evidence of discriminant validity, which differentiates between performance of children from the normative sample and that of children with various conditions (Bayley, 2006b).

**Data Analysis**

Descriptive statistics were used to show the characteristics of the participants (Table 1). A paired t test was applied to analyze the scaled scores from the Bayley–III between its two administrations: at the beginning of ISEEI enrollment and after 3–9 mo of program participation (Tables 2 and 3). Because more than one hypothesis was tested in a single dataset, Bonferroni adjustment was used to reduce the probability of finding significant results as a result of chance (Type 1 errors or false-positive results). Results are presented in Tables 2 and 3.

**Results**

**Effectiveness of ISEEI for Children With Developmental Delays**

After children with developmental delays received 3–9 mo of ISEEI, they showed significant overall improvements in all performance areas, including cognition (p < .001), language (both receptive and expressive, p < .001), fine motor skills (p = .03), and gross motor skills (p < .001; see Table 2). Of the parents of 63 children, 12 completed the socioemotional and adaptive behaviors questionnaires. On the basis of these limited data returned by parents, no significance was found.

**Effectiveness of ISEEI for Children With Sensory Processing Difficulties**

We separately examined the group of children with sensory processing difficulties (n = 44) and the group without sensory processing difficulties (n = 19). Results show that although there was no significant difference in Bayley–III scaled scores at the time of enrollment, there was a difference between both groups post-ISEEI. The group with sensory processing difficulties exhibited significant improvements in cognition, gross motor skills,

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>M (SD) or n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mo</td>
<td>28.7 (4.1)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>41 (65)</td>
</tr>
<tr>
<td>Female</td>
<td>22 (35)</td>
</tr>
<tr>
<td>Reason for referral</td>
<td></td>
</tr>
<tr>
<td>Speech/social delays</td>
<td>26 (41)</td>
</tr>
<tr>
<td>Developmental delays</td>
<td>25 (40)</td>
</tr>
<tr>
<td>Neurological/genetic</td>
<td>6 (9)</td>
</tr>
<tr>
<td>ASD</td>
<td>5 (8)</td>
</tr>
<tr>
<td>Behavior</td>
<td>1 (2)</td>
</tr>
</tbody>
</table>

Note. ASD = autism spectrum disorder; M = mean; SD = standard deviation.
and expressive and receptive language, whereas the group without sensory processing difficulties exhibited significant improvements only in cognition and expressive and receptive language (see Table 3). These results indicate that ISEEI, a program informed by SI theory, has better results on motor performance for children with sensory processing difficulties than for children without such difficulties.

**Discussion**

The effectiveness of the ISEEI group program, as measured by positive changes in scaled scores, indicates that the children’s improvements were not just related to an increase in skill acquisition as a result of development alone, but that progress was substantial when compared with typical development as reported in the Bayley–III results. Overall, the results provide evidence that an interdisciplinary sensory-enriched EI program delivered in a group setting is effective in reducing developmental delays in motor, language, and cognitive areas in children with developmental delays. Moreover, the results demonstrate that such a program is particularly effective with children who exhibit sensory processing difficulties as identified by the ITSP.

The children in this study did not show statistically significant changes in fine motor development, which might suggest that this program is not effective when targeting that area. However, a review of the fine motor scores obtained on the Bayley–III indicates that this was not an area of need in these children. Moreover, many of the children in the sample presented perceptual–motor and motor-planning difficulties that affected their ability to engage in symbolic play and to interact with constructional material; therefore, the Cognitive scale of the Bayley–III, which includes copying and imitation items, appears to be a better measure of progress in this area.

### Table 2. Bayley–III Scaled Scores Before and After the Program

<table>
<thead>
<tr>
<th>Area</th>
<th>At ISEEI Enrollment, $M \text{ (SD)}$</th>
<th>After 3–9 Mo ISEEI Participation, $M \text{ (SD)}$</th>
<th>$t$</th>
<th>$df$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Test, $n = 63$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognition</td>
<td>7.84 (3.44)</td>
<td>9.35 (2.91)</td>
<td>4.18</td>
<td>62</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Receptive Language</td>
<td>7.57 (3.68)</td>
<td>9.65 (3.63)</td>
<td>5.61</td>
<td>62</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Expressive Language</td>
<td>6.71 (3.19)</td>
<td>8.94 (4.01)</td>
<td>7.04</td>
<td>62</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Fine Motor</td>
<td>9.10 (3.02)</td>
<td>9.87 (2.73)</td>
<td>2.20</td>
<td>62</td>
<td>.03</td>
</tr>
<tr>
<td>Gross Motor</td>
<td>7.41 (2.45)</td>
<td>8.46 (2.45)</td>
<td>4.05</td>
<td>62</td>
<td>&lt;.001*</td>
</tr>
</tbody>
</table>

**Note.** Bayley–III = Bayley Scales of Infant and Toddler Development III; ISEEI = Interdisciplinary Sensory-Enriched Early Intervention; $M = \text{mean}; SD = \text{standard deviation}$. *Adjusted for multiple comparisons using Bonferroni method; $p < .01$ is considered a significant difference.

### Table 3. Bayley–III Scaled Scores Before and After the Program for Children With and Without Sensory Processing Difficulties

<table>
<thead>
<tr>
<th>Area</th>
<th>At ISEEI Enrollment, $M \text{ (SD)}$</th>
<th>After 3–9 Mo ISEEI Participation, $M \text{ (SD)}$</th>
<th>$t$</th>
<th>$df$</th>
<th>$p^*$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children With Sensory Processing Difficulties, $n = 44$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognition</td>
<td>7.75 (3.68)</td>
<td>9.16 (3.08)</td>
<td>3.06</td>
<td>43</td>
<td>.004**</td>
</tr>
<tr>
<td>Receptive Language</td>
<td>7.48 (3.93)</td>
<td>9.45 (3.52)</td>
<td>4.36</td>
<td>43</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Expressive Language</td>
<td>6.68 (3.32)</td>
<td>8.73 (4.08)</td>
<td>5.24</td>
<td>43</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Fine Motor</td>
<td>9.02 (3.25)</td>
<td>9.64 (3.00)</td>
<td>1.34</td>
<td>43</td>
<td>.186</td>
</tr>
<tr>
<td>Gross Motor</td>
<td>7.30 (2.21)</td>
<td>8.39 (2.43)</td>
<td>3.88</td>
<td>43</td>
<td>&lt;.001**</td>
</tr>
</tbody>
</table>

| Children Without Sensory Processing Difficulties, $n = 19$ |                                       |                                                  |      |      |      |
| Cognition             | 8.05 (2.90)                           | 9.79 (2.51)                                      | 3.12 | 18   | .006**|
| Receptive Language    | 7.79 (3.08)                           | 10.11 (3.93)                                     | 3.54 | 18   | .002**|
| Expressive Language   | 6.79 (2.95)                           | 9.42 (3.92)                                      | 4.96 | 18   | <.001**|
| Fine Motor            | 9.26 (2.47)                           | 10.42 (1.92)                                     | 2.28 | 18   | .035  |
| Gross Motor           | 7.68 (3.00)                           | 8.63 (2.54)                                      | 1.66 | 18   | .113  |

*Note.** Bayley–III = Bayley Scales of Infant and Toddler Development III; ISEEI = Interdisciplinary Sensory-Enriched Early Intervention; $M = \text{mean}; SD = \text{standard deviation}$. *Adjusted for multiple comparisons using Bonferroni method; $p < .01$ is considered a significant difference. **Significant differences after adjustments. ***Significant differences after adjustments.
Although the study did not measure the children’s increased engagement in play and other changes in occupational performance, anecdotal parent reports and qualitative observations in natural environments support the impact of these children’s developmental gains on participation. Because of the low number of parents (n = 12) who returned the social–emotional and adaptive questionnaires of the Bayley–III, a valid comparison between pre- and postprogram was not possible, suggesting a need for future studies.

This program cannot be considered equivalent to individualized SI treatment; however, the gym section of the program contains two structure elements of ASI and six process elements as defined by the fidelity measure (Parham et al., 2011). The structure elements were the therapists’ qualifications and the safe environment. The process elements were ensuring physical safety, presenting sensory opportunities, supporting self-regulation, challenging motor abilities, supporting child direction (including the just-right challenge), and establishing a therapeutic bond. Moreover, the study supports the application of SI principles by an interdisciplinary team and in a group setting.

Note that this study included children with a variety of conditions, from general developmental delays to specific diagnoses such as ASD and genetic disorders. This diversity suggests the ISEEI group program can have far-reaching effects, with results not bound to a single diagnosis. In the world of EI, this observation is important because children are often referred to programs before receiving or as they are undergoing testing to receive a formal diagnosis.

Limitations

The limitations of this study include its retrospective nature based on a sample of convenience and its lack of a control group. In addition, therapists who were also trained raters were not blinded; however, in this program, raters are not necessarily the same for pre- and posttests. Future studies need to include a control group that participates in programs that do not include a sensory-rich environment based on SI theories. They also need to provide systematic reevaluation of children every 3 mo to identify when most of the changes occur during program participation. Future studies should also include a measure of social–emotional development and participation as well as an observational measure of sensory processing.

Implications for Occupational Therapy Practice

Occupational therapy practitioners are critical members of interdisciplinary teams that develop EI programs because their understanding of sensory processing and development enhances the delivery of such programs. This study has the following implications for occupational therapy practice:

- Children with developmental delays need to be identified and given interventions early. Occupational therapists need to be part of the teams that identify these children.
- Understanding sensory processing and its effect on development is crucial in EI.
- Systematic assessment of sensory processing and development is necessary in the delivery of any program and particularly in EI.
- Systematizing interventions so that they can be reproduced helps develop the evidence for the effectiveness of occupational therapy.
- Using sensory-enriched environments in EI can produce change in the developmental curve as measured by the Bayley–III.

Conclusion

The results of this study are significant in many ways. First, even when only 22% of the children in ISEEI received the diagnosis of ASD, the program followed many of the previously described recommendations for children with ASD by the National Academy of Sciences and National Research Council (2001), Sullivan et al. (2014), and Wallace and Rogers (2010), including parental training, an intensive program (at least 25 hr per week), interventions comprising short time intervals, a low student-to-adult ratio (3:1), and ongoing assessment of children’s progress. The program’s effectiveness suggests that these recommendations should be followed by EI programs.

Second, the results support the use of SBIs as defined by Case-Smith et al. (2015) in the form of a sensory-enriched program for all children with developmental delays. Note that the application of such a program first needs to be structured, preferably in the form of a manualized program as has been recommended in the literature (Blanche, Fogelberg, Diaz, Carlson, & Clark, 2011), and measured in preestablished intervals. Additionally, the results indicate that for children with developmental delays and sensory processing difficulties, the application of a sensory-enriched program can be particularly effective. Moreover, the use of SBIs should be based on the sensory processing difficulties presented by the child and should be applied with a thorough understanding of SI theories.

Finally, these results are important for policy development. This retrospective study supports the early
identification and use of intervention for children with developmental delays who are at risk for long-term developmental disabilities. This study also shows that if children receive EI, their developmental trajectory can be altered, potentially saving resources later in life. Overall, this study supports previous studies that focused on EI for children with ASD and other developmental disabilities and lends added credibility to the inclusion of occupational therapy practitioners as important contributors to interdisciplinary EI teams that deliver programs for children younger than age 3 yr. ▲

References


