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Team Around the Child (TAC): The small collaborative team in early childhood intervention for children and families who require ongoing multiple interventions

Peter Limbrick

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Summary
This article gives a thorough account of the Team Around the Child (TAC) approach which is now generally accepted as good practice in the UK and other countries. It describes some of the main problems for children and families that arise when there are ongoing multiple interventions. TAC is offered as an antidote to them and is defined as a small collaborative team of just a few people (including the parent) that can co-ordinate all interventions and collaborate closely on the child's development and learning programmes. When members of a TAC trust each other sufficiently, TAC can become a transdisciplinary approach.

Introduction
Effective early childhood intervention for all babies and young children with disabilities requires joint working between all the practitioners involved and between practitioners and parents. Varying degrees of joint working are applicable to children and families according to need. The Team Around the Child (TAC) approach facilitates the highest degree of joint working for children and families with complex needs. The approach enables each child's key practitioners and parent to collaborate with each other to achieve collective competence and provides them with an opportunity to operate a transdisciplinary model in which practitioners act as consultants to a primary interventionist.

The Team Around the Child (TAC) Approach
The account of a TAC meeting in Figure 1 is offered as a practical illustration of how the approach works. The imagined scene can be happening in the family's home, in a local centre, in a health, education, social care or independent sector base or in another venue which suits the family's needs for place, date and timing.

Figure 1: TAC in action

> There are six people present; a baby (with his mother when he is not asleep in his buggy), the baby's mother, the physiotherapist, the speech & language therapist, the pre-school visual impairment teacher and the family's keyworker (or lead professional) who is also the baby's health visitor. These comprise the child and family's present TAC and it is the third TAC meeting since the baby was discharged from the Special Care Baby Unit some months ago. Everyone is smiling at the moment because, for the first time, the baby has just appeared to visually track a moving toy.

Most of the meeting so far has been taken up by a detailed discussion of feeding. As keyworker, tasked with leading the meeting through its agenda, the health visitor is the only one with an open file on her lap. She is sitting on the sofa with the mother and was thus in a good position to offer some warm support and reassurance half an hour ago when the mother shed tears of frustration about the baby's weight. The two therapists are kneeling on the floor because they were working with the baby to explore feeding positions.

The mother, visual impairment teacher and the health visitor were all able to contribute fully to the discussion using their own expertise and knowledge of the baby. The result was a detailed whole-child plan for mealtimes including positions, choice of spoon, cup and dish, type and quantity of food, oral functions and use of language, signals and prompts. The mother was reassured to have a group discussion on this important issue with a clear consensus on how to proceed. The broader discussion which followed addressed the following issues:

1. Possible interventions should the feeding problems continue.
2. How to get the older child to school leaving the mother free to give the baby breakfast without rush.
3. The forthcoming routine appointment with the consultant paediatrician. It was agreed the health visitor would accompany the mother to help in a discussion about the baby's nutritional status.
4. The forthcoming appointment with the dietician. It was agreed that the speech and language therapist would approach her to see if she (the dietician) could join the session with the consultant paediatrician instead of having a separate session – which the mother could not easily attend.

After agreeing the various elements of the plan of action, the meeting ended by fixing a date, time and venue for the next TAC meeting in a few weeks' time. Because the baby's father had said he would like to start coming to TAC meetings when he can, the next meeting was fixed with his work pattern in mind.

This baby can be described as having 'complex needs'. She has neurological impairment and consequent difficulties in posture, movement, hand function, vision, eating, drinking, sleeping, vocalising and communication. Time will tell if she has any learning or hearing disability. Very many practitioners have become involved since birth but the ones above are those presently offering the most regular and practical interventions. The discussion, rather than covering all possible aspects of child development, focused instead on the pressing issue of feeding and nutrition – an issue of current deep concern for the mother and with serious implication for the baby. However, the agreed multi-disciplinary plan included ample opportunities to promote posture, movement, language, etc, as well as specific feeding skills – an integrated, needs-led, and child- and family-centred approach.

A group of practitioners from services who have pioneered TAC in England and Scotland have agreed the following working definition of TAC:

The Team Around the Child approach has been designed to provide effective, timely and seamless support for children and young people with complex needs and their families ('family' being defined by each child's circumstances). It supports child- and young person-focused family-centred planning and provides each child and young person with their own individual, collaborative team of practitioners.

Minutes of meeting

The phrase 'complex needs' is in common usage but has no nationally agreed definition. It often describes a group of children with ongoing disabilities and health needs. The defining characteristic for me of the group is broader. Children and families with complex needs are those for whom the plurality of interventions is itself a problem, or is in danger of becoming a problem, by over-burdening the family and being counterproductive to the child. When a child has 'complex needs' we should immediately address any actual or potential problematic complexity in service provision.

Figure 2 at the top of page 3 outlines this problematic complexity in terms of the potential ill effects of fragmented service provision on the family and on the child who requires ongoing multiple interventions. Once the situation is described in these terms, some practical approaches to resolving the complexity become obvious.

TAC comes indirectly from the work of One Hundred Hours (Limbrick-Spencer, G. 2001).[1] This voluntary organisation pioneered keyworking during the 1990s for families of babies and young children with complex needs. The model was then refined in my consultative work with service providers across the UK who wanted to achieve joint working but did not have funds for full-time One-Hundred-Hours-type keyworkers. These managers and practitioners, with

[1] References are listed at the end of the essay

Figure 2: Problems which can arise when there are ongoing multiple interventions

For parents and siblings	**For babies and pre-school children with disabilities / special needs**
When there is no attempt to co-ordinate and rationalise the pattern of home visits, assessments, education/therapy interventions, meetings, etc. or to help with child care and travel for the various clinics, centres and hospitals, the result can be:	When practitioners, whether from health, education, therapy or care services, keep their interventions separate from each other:
1. An almost impossible and escalating daily and weekly routine which the parent struggles to maintain so that the child is not denied anything which could be valuable.	1. The child might have to relate to, and accept 'hands-on' interventions from more people than he is comfortable with.
2. No opportunities for the parent to work, study or socialise – activities which could be a welcome break from the daily round.	2. Interventions are piecemeal rather than whole-child – as though language, movement, cognition, socialising, etc, could operate independently of each other.
3. An overload of separate items of advice, suggestions and separate discipline-specific home programmes. Parents can be ambivalent about these, feeling they should do them but really preferring just being a parent to becoming a sort of 'teacher/therapist'.	3. Discipline-specific programmes might not be compatible with each other. For instance, a child will be confused if in a speech & language therapy session he has to sit and sign for a toy while in a physiotherapy session he has to move in some way to get what he wants.
4. Unresolved contradictions in advice about helpful approaches, treatment, medication and surgery.	4. Attitudes, approaches and programmes might be quite different in each place where the child regularly plays and works, e.g. nursery, centre and home.
5. Siblings being sidelined within the family.	5. Practitioners have no opportunity to jointly consider how each condition or disability impacts on the others or to plan strategies which connect disabilities together.
The result can be an exhausted family suffering a gradual erosion of time, money, energy and spirit with no prospect of any sort of normal and positive family life. Such a family is made more vulnerable by these fragmented services.	The result can be that the child's opportunities for development and learning are reduced or nullified.

children who require ongoing multiple interventions in mind, considered TAC to be a better fit with their existing resources and practitioner roles.

The TAC approach is designed as an antidote to the following:

1. **Fragmentation of support:** This includes an uncoordinated and often chaotic pattern of appointments, meetings, assessments, etc, with the possibility of duplication, gaps and mismatches in provision.
2. **Parents who are sidelined:** Many parents complain that they are not allowed to be equal partners in decision making for their child and family.
3. **A piecemeal approach to the child's development and learning:** This comes from the mistaken view, in my opinion, that we can cater for babies and young children as though such functions as posture, movement, language, play, cognition, socialising, etc, operate in isolation from each other.

TAC and joint working

This section discusses how TAC facilitates joint working in early childhood intervention. There are four headings:

1. The need for joint working at appropriate levels.
2. TAC: a collective effort within a matrix of shared responsibilities.
3. Collective competence.
4. TAC and transdisciplinary teamwork.
5. TAC and keyworking.

1. The need for joint working at appropriate levels
Dr. Penny Lacey (Lacey, P. 2001) describes how people can work together at increasing levels of closeness according to child and family need. She suggests that collaborative teamwork is necessary when needs are complex:

Liaison, cooperation, coordination and collaboration are often, erroneously, used inter-changeably. These terms can be conceived on a continuum, with liaison indicating the least degree of communication between agencies or professionals through to collaboration indicating the most (Lacey, 1995). Payne (1993) defines liaison as making contact with other organisations and sustaining this contact. This seems to be the first step towards cooperation which denotes the minimum manner in which two organisations or professionals can work together. They take specific steps to ensure that they do not cut across each other's work or otherwise hinder each other.

The next stage is coordination, where organisations and individuals 'work together when this is necessary' (Payne, 1993, p.4) by streamlining services and timetabling so that children and their families receive a well thought out package of care and education. The final point on the continuum, collaboration, includes processes such as sharing, trusting and handing over skills, joint assessments and mutual training. Professional boundaries are crossed naturally in the effort to meet a complexity of needs.

Lacey equates collaborative teamwork with transdisciplinary teamwork and says of both:

…the importance of a keyworker and a small team in direct contact with children and their families can be appreciated. This helps to prevent a multiplicity of personnel overwhelming families with alternative or even conflicting advice. Most contact with the child and family is through the keyworker and small team, although direct contact with others may be desirable, especially if needs change dramatically and specialist assessment is required.

Deborah Chen (Chen, D. 1999) in speaking of the situation in the USA, champions collaborative teamwork as follows:

In the transdisciplinary model, service providers of various disciplines collaborate to conduct assessments to plan and implement interventions. Families are active members of the transdisciplinary team, and interventions are integrated into the daily routines.
…the transdisciplinary approach is essential for providing effective early intervention services to families and their infants with disabilities, especially those with significant disabilities.

There is consensus here that effective support for children and families with the most complex ongoing needs requires a small individualised collaborative team as offered by both TAC and transdisciplinary approaches.

2. TAC: a collective effort within a matrix of shared responsibilities
Each TAC is defined as much by the practitioners who are not members of it as by those who are. In a TAC system it is essential to maintain the involvement of those practitioners who provide essential interventions to a particular child and family on a less regular or less close basis than do those in the TAC at that time. For each child, these are the ten, twenty, thirty or more 'peripheral' practitioners (Limbrick, 2001, p.5) or the 'network of people in intermittent contact' in Lacey's terms (Lacey, 2001, p.12). Each practitioner involved in some way with a particular child becomes part of a collective effort and assumes a professional responsibility to joint work at appropriate levels with the others. This matrix of shared responsibilities is the antidote to what Lacey terms 'benevolent chaos' (Lacey, 2001, p.141) and is a complex pattern in which practitioners switch as necessary between the modes of liaison, co-operation, co-ordination and collaboration in pursuit of effective support for each individual child.

There has always been a need for practitioners to work together but, without any agreed structure, joint work has been largely left to the discretion of individual practitioners working under their own initiative. For many families support resembles an attempt at a symphony by musicians without a conductor – and with sections of the orchestra in separate concert halls. There is much work to be done by health, education and social services and the independent sector at strategic level in pursuit of seamless early support and *Together From The Start* (DfES/DH, 2003), *DfES Early Support* and *Every Child Matters* (DfES, 2003) have set the scene for this in England.

In practical terms, we can construct this matrix of shared responsibilities and facilitate the collective effort within it at two levels in each locality:

1. Each child's TAC practitioners and their line managers can help orchestrate support, for they sit with the family at the centre of the network, understanding the whole picture of child and family strengths and needs, and being aware of all the current and planned interventions. Whilst TAC members are collaborating closely with each other they can encourage and facilitate appropriate joint working between other services and practitioners.
2. At the strategic level, each agency, whether a children's service, health trust, education department, social service department, voluntary organisation or private agency, could promote shared responsibility

and collective effort by agreeing a code of practice. Figure 3 offers a starting point for this.

It is the responsibility of each practitioner who is supporting a child and family who require ongoing multiple interventions, or who is meeting such a child and family for the first time, to consider:

- With whom do I need to network/liaise?
- With whom do I need to co-ordinate my interventions?
- With whom do I need to collaborate closely?
- With whom do I need to work to achieve collective competence?

To construct and maintain the network of shared responsibility, such a protocol would have to apply to every practitioner at every level in each local agency or service. The aim of the protocol would be for shared responsibility to become eventually part of local professional culture.

Figure 3: A code of practice to promote shared responsibility

3. Collective competence

This concept, which I have termed 'collective competence', asserts that when a child has more than one significant disability no practitioner can be fully competent while operating independently of others. To illustrate collective competence we can imagine a blind baby with cerebral palsy whose key practitioners are a paediatric physiotherapist and a visual impairment home-visiting teacher, and whose main carer is his mother. We can consider the separate competencies of the baby's mother, the therapist and the teacher to provide effective whole-child interventions for the baby. The mother in this scenario knows all about her baby's growing personality, habits and preferences, is developing a mother/baby relationship with communication and affection, is encouraging some early play and independence and has already learned much about how to care for her baby's everyday needs. However, she cannot be competent on her own to meet the child's development and learning needs because at this stage she has a tremendous amount to learn about blindness, about cerebral palsy and about what she can do to help her new baby manage these combined conditions. She will surely become very knowledgeable about these disabilities eventually, but during the first years she is inevitably a learner. The paediatric physiotherapist knows how to promote posture and movement in sighted children, but how will she encourage a blind child to lift his head while lying on his tummy? Can the baby be encouraged to roll when he does not yet 'know' if the floor will still be there when he moves? The visual impairment teacher knows how to promote play, communication and independence in her children but how will she achieve this when the baby cannot sit or hold his head up and has only limited use of his hands? The answer must be that competence in a whole-child approach to this baby can only be achieved by all three working closely together – collective competence.

Another factor in this argument for collective competence is the lack of research into effective interventions for children with multiple disability. Practitioners cannot reach for textbooks of good practice for every possible combination of two, three, four or more conditions and disabilities – and will never be able to do so. While we have to resort to trial-and-error approaches and learn about each child 'as we go along', it is surely good practice to aim for collective competence in small collaborative teams rather than trying to get by on our own. For these children two (or more) heads are likely to be better than one and it seems fair to assume that a plan coming out of shared knowledge of the child and with shared concern and expertise is going to be superior to any strategy devised by a lone operator. TAC ideology argues that this collective competence can only be fully expressed and exploited when each child's key interventionists meet regularly face-to-face in TAC meetings to share observations, aspirations and skills and to agree a joint action plan.

4. TAC and transdisciplinary teamwork

In my experience, there can be a continuum of collaboration between practitioners within the TAC approach, and the term 'transdisciplinary' only applies to those individual TACs in which practitioners have agreed to collaborate most closely. The following descriptions illustrate how practitioners can collaborate at the two ends of this continuum.

Lesser collaboration: In the TAC meeting practitioners and parent share views on the current needs of the child and inform each other about the approaches they are using and the goals they are working towards. Collaboration might then include the following processes:

1. Any instances of contradictory views, approaches or goals are ironed out.
2. If the whole picture of interventions, when constructed at the meeting, appears to be either overloading child and/or family or not providing enough opportunities to the child or support for the family, then adjustments are agreed This might include prioritisation of interventions and agreements about involving additional services or practitioners.
3. Agreement about consistency in such basic functions as positioning, communication, hand

function, etc, which are integral to everything the child does.
4. Agreement to promote each other's goals when appropriate. As an example, if the physiotherapist is promoting rolling on the floor, a sensory impairment teacher will encourage the child to roll when playing on the floor with the toys she is using in her programmes. In turn, the physiotherapist will integrate the same toys into her work and use them with the child in the same way as the teacher does. This obviously depends on a willingness to share information.

Greater collaboration: Orelove and Sobsey (1991) describe the trans-disciplinary team model as follows:

Originally designed to serve infants at high risk for disabilities (Hutchinson, 1978; United Cerebral Palsy Associations, 1976), the transdisciplinary model has been embraced by programs serving children with multiple disabilities. The model is characterised by a sharing, or transferring, of information and skills across traditional disciplinary boundaries. In contrast to multidisciplinary and interdisciplinary approaches, the transdisciplinary model incorporates an indirect model of services, whereby one or two person(s) is the primary facilitator of services and other team members act as consultants (Albano et al, 1981).

In the illustration above of lesser collaboration the people in the child's TAC agreed to promote each other's efforts. The members of the well established TAC, when they know and trust each other sufficiently, can go much further by agreeing to radically modify how their interventions are presented to the child. The two main possibilities are as follows:

1. **Integration of separate programmes:** Education and therapy interventions for the child's development and learning, instead of remaining as separate discipline-specific programmes which are perhaps offered to the child at separate times and venues, are integrated as far as is appropriate into the child's daily routine of mealtime, bath-time, bedtime, dressing, moving around, socialising, playing, etc. This approach recognises that all of the child's functions are interconnected and interdependent, and results in interventions which appear relevant and meaningful to both child and parent and which they will feel are worth doing.

2. **The primary interventionist:** The primary interventionist is a practitioner who, by agreement within the TAC and for an agreed period of time, does more work with the child and parent than do the other key practitioners. The role has validity for babies and children who cannot yet form multiple relationships or accommodate more than one or two people handling and working with them. In early childhood intervention the primary interventionist works in a threesome with child and parent and becomes the main person providing the baby or young child, in partnership with the parent, with those development and learning opportunities prescribed by the other key practitioners. Any of the child's practitioners, for example, specialist teacher, therapist, nursery nurse or Portage worker, can become the primary interventionist for a specified period. Figure 4 overpage shows how the primary interventionist functions within the TAC system and, importantly, how the other key practitioners maintain their contact with the child and family. This level of contact is agreed with the parent by each key practitioner and is written into the Family Service Plan.

This transdisciplinary approach with its integrated programmes and primary interventionist is intended to give the child increased exposure to development and learning opportunities and must be validated by each practitioner and parent genuinely perceiving that everyone's skills, knowledge and experience are impacting on the child and family more effectively than in the traditional model of separate interventions and multiple programmes. Practitioners are invited to soften (but not eliminate) their professional boundaries and to work within a consultant model, sharing skills, knowledge and understanding with trusted colleagues.

Though each individual TAC must be given the authority and flexibility to come to its own decision about integrating programmes and nominating a primary interventionist, a prerequisite of success is a multi-agency commitment at strategic level to training in the transdisciplinary model and establishing a code of practice to ensure standards are maintained at the highest level. Figure 5 offers a starting point for such a code of practice (which, incidentally, could also be applied to any practitioners who hand over some aspects of their work to parents in traditional approaches).

It is the responsibility of the practitioner who is handing over some work to a primary interventionist to:

- satisfy herself that the primary interventionist is competent to take on the work
- ensure that all necessary training and instruction has been given to the primary interventionist – with notes or video to refer to when necessary
- ensure the primary interventionist has all necessary time, space and equipment
- be available to provide ongoing support as necessary to the primary interventionist

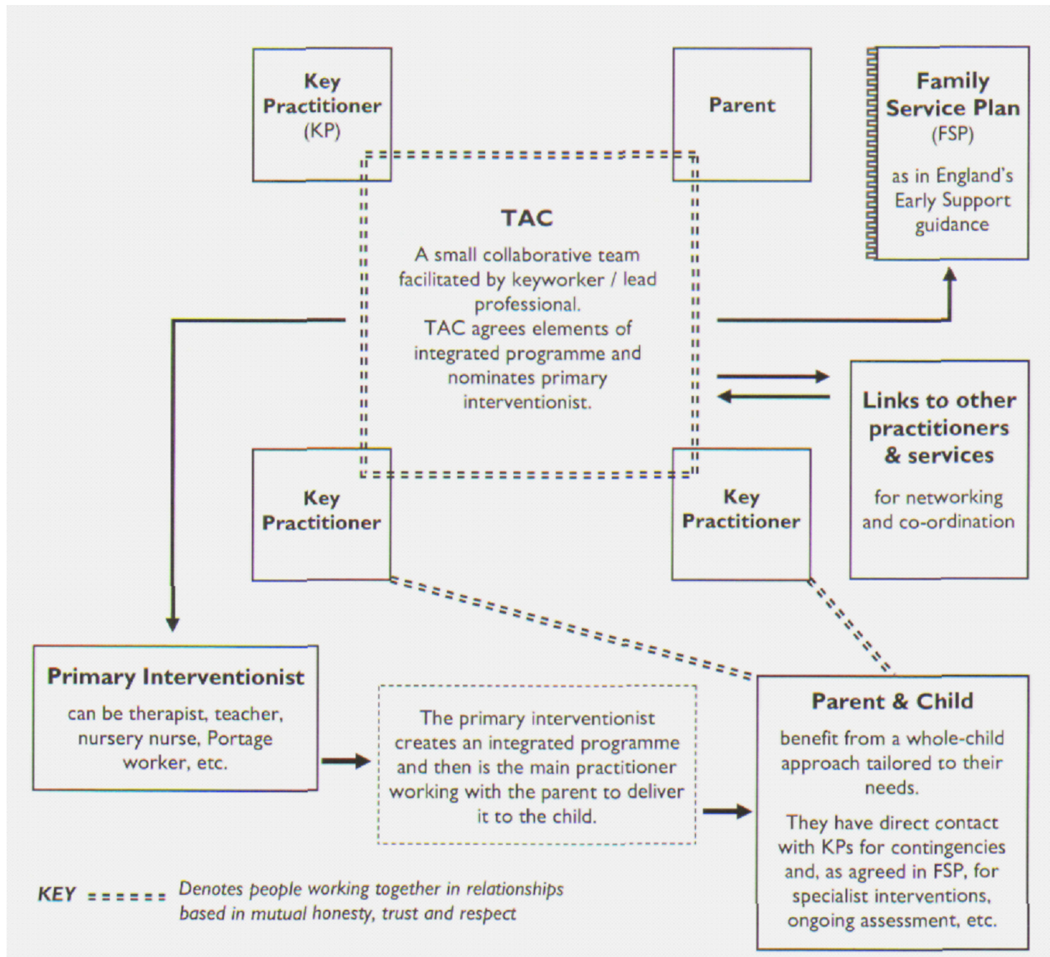

Figure 4: The primary interventionist within the TAC system

- monitor the primary interventionist's performance, give constructive feedback and be willing to receive constructive feedback about the support offered

These protocols should apply whether the handover is to a practitioner of equal professional standing, to a practitioner who has a lower level of training and experience, or to a practitioner with a higher level. This is the essence of the transdisciplinary approach in which skills are shared within genuine and equal partnerships based on mutual honesty, trust and respect.

Figure 5: A code of practice for practitioners acting as consultants to a primary interventionist

5. TAC and keyworking

The guidance *Together From The Start* (DfES/DH, 2003) recommends that all children with complex needs and their families should have a keyworker and begins its definition of the role with:

A keyworker is both a source of support for the families of disabled children and a link by which other services are accessed and used effectively.

DfES Early Support Professional Guidance (DfES, 2004) acknowledges the need for practitioners to work together in escalating degrees in response to increasing levels of need in children and families and, focusing on the keyworking role, describes a spectrum from less need for a keyworker or lead professional (when there is a single agency in contact with family and a single, relatively mild or transitory condition in child) to more need (when there are many individuals or agencies in contact with family and multiple/relatively severe conditions in child). They recommend three levels of

provision on this escalating spectrum as follows (with numbers inserted for clarity):

1. 'Befriending service' helpful. Community-based information services. Contact for more information clearly identified.
2. Some keyworking or care co-ordination required. More regular contact with family needed to ensure continuity of care.
3. Full 'Team Around the Child', keyworker or lead professional service required.

Together From The Start refers to Himmelman (Himmelman, 1996) who offers a continuum of co-ordination from networking, through co-ordination and then co-operation to collaboration. This is clearly a different interpretation of these individual processes from that in Lacey's sequence of liaison, co-operation, co-ordination and collaboration. The experience of One Hundred Hours suggests a practical application of the continuum of increasing joint working which might simplify the issue. The One Hundred Hours keyworker in the 1990s facilitated joint working on an escalating continuum with three recognisable stages described as follows:

1. Keyworker as Named Person. This practitioner befriends the family, provides some emotional support, helps the parents with information and access to services and ensures the child and family are properly embedded in the local networks. In my experience, most families of disabled children will benefit from this support.

2. Keyworker as Co-ordinator. When there are multiple interventions this practitioner works with the family to achieve the best possible co-ordination and rationalisation of the separate appointments, meetings and assessments with careful consideration of the family's routines, finances, travel needs, other children, etc.

3. Keyworker as TAC Facilitator. This practitioner is a member of the TAC with a specific and limited role which includes supporting the family through the TAC process, helping each TAC meeting to arrive at a multi-agency action plan or 'Family Service Plan' (in England's Early Support terms) and making sure the child and family receive all the support that is agreed in the plan.

In this tiered One Hundred Hours model, which is built on a three-part joint working sequence of networking, co-ordination and collaboration, each level of keyworking embraces the previous levels and the keyworker becomes the agent who facilitates the gearing up and the gearing down through the levels of joint working to accommodate changes in the child's condition and the family's situation. The majority of keyworkers and lead professionals in the UK are practitioners who take on this new role alongside their main role as therapist, teacher, health visitor, etc. To avoid overload, the additional tasks in the keyworking or lead professional role at whichever level must be kept to a minimum. In the TAC approach, the keyworker is supported by the other TAC members who share the workload with her – as might be expected in a genuinely collaborative effort.

TAC, systems thinking and plain common sense

The TAC approach can form the heart of a locality's multi-agency strategic plans for effective early childhood intervention for children who have more than one condition, disability or need. The approach conforms to the discipline of systems thinking and appeals to most people's common sense.

Systems thinking: Systems thinking emerged during the last century as an attempt to describe how the world works. The people who developed systems thinking then, and those involved in it now, come from many disciplines including biology, engineering, sociology and physics. Their creed is that everything we can think of is part of a system and does not function on its own. This applies to systems themselves which are comprised of smaller systems and which join together into more complex systems. Whether we are thinking about a brain cell, a kidney, a baby, a family, a supermarket, a car factory or a multi-national bank, we are not going to get very far in diagnosing problems or designing helpful interventions if we focus on individual parts and ignore how each part relates to the other parts. The functioning of any system depends on interconnections and relationships. Each part depends on the other parts and nothing exists on its own. For a longer account of a systems approach to children with multiple disabilities see Limbrick (2007). For an introduction to systems thinking see Bertalanffy (1968).

A systems thinking approach to a child and family who have complex needs would inspire service providers to:

- perceive the child as whole and not as a collection of discrete parts with separate functions
- acknowledge the child as part of a family and then consider child and family within their own support network and community
- recognise that the child and family's practitioners should be interconnected and interdependent, and then facilitate them joining together in a collective effort or 'intervention system'
- consider each of the child's conditions and disabilities to be interconnected and to consider how each impacts on the others

Systems thinking suggests to me that an individual

practitioner working with a child who has multiple needs cannot function effectively on her own – just as her car engine cannot function to get her to work in the morning without the wheels, body, control pedals, etc, that make up the whole functioning system of her car. With these children, rather than thinking we can carry on doing '*our own sweet thing*' (in the words of some disillusioned parents I met recently), we have to discard the idea of individual competence and accept in its place the concept of collective competence. While we lose some independence we benefit from being in a supportive team. While we lose some autonomy we develop a broader understanding and acquire new skills – the 'cognitive gain' that Penny Lacey refers to in her essay on page 53 in this book.

Common sense: Most people who are not yet initiated into disability issues would expect that the key practitioners supporting a child with multiple needs would meet to share opinions and agree a plan of action. When new parents of children with disabilities become frustrated and disillusioned with their support (and very many do) it is often, at least in part, because they are very disappointed and worried to discover that their key practitioners are each doing 'their own sweet thing'. For many frustrated practitioners I have met who feel disempowered by the fragmented nature of their local services, the phrase 'Team Around the Child' itself evokes a possible solution to fragmentation even before they learn more about the approach.

This is a fitting note on which to conclude: TAC is a common sense approach. There should really be no need to muster a collection of educational, psychological, sociological or philosophical theories to argue that, when a number of practitioners are closely involved with the same child and family, they, and the parent, should be given time and space to get to know each other, to pool thoughts and ideas, and to agree the best possible joined-up plan.

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